17 MARCH 2001

CHEMIST & DRUGGIST

THE NEWSWEEKLY FOR PHARMACY

DoH puts up £1.9m for medicine pilots

Hunt accepts doctor dispensing/Clothier 'loophole' trade off

Wales gives £10k for osteoporosis project

New CPO, Jim Smith, gives first full interview

Boots' 'Wellbeing' channel goes on air

Update: don't let the drugs get you down

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The first (7) day OTC treatment for mild athlete's foot*

***Between the toes** (1) Hams R. et al Antimicrobial Agents and Chemotherapy 1983; Vol 24 (6) 876-882 (2) Data on file

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Johnson & Johnson ○ MSD
CONSUMER PHARMACEUTICALS

Daktarin™ Gold Product Information.
Presentation: White cream containing ketoconazole 2% w/w. **Indications:** Tinea pedis, tinea cruris and candidal intertrigo. **Dosage and Administration:** For mild athlete s foot: apply twice a day for one week. For more severe or extensive athlete s foot (eg also affecting the sole or sides of the feet), continue to apply the cream for at least 2-3 days after symptoms have cleared to prevent them coming back. For Dhobie Itch and Candidal Intertrigo: apply once or twice daily for at least 2-3 days after symptoms have cleared. **Contra-indications:** Hypersensitivity to any of the ingredients or to ketoconazole itself. **Precautions:** Not for ophthalmic use. **Interactions:** None known except possible corticosteroid interaction. **Pregnancy and lactation:** Not to be used in pregnant women. May be used during lactation. **Side effects:** Irritation, dermatitis and burning sensation may be observed. **Overdose:** In accidental oral ingestion, consider appropriate methods of gastric emptying. **Legal Category:** P. **PL:** PL0242/0107. **Price:** 15g tube £4.99. **PL Holder:** Janssen-Cilag Ltd, Saunderton, High Wycombe, Bucks, HP14 4HJ. **Date of preparation:** Jan 2001

CHEMIST & DRUGGIST

THE NEWSWEEKLY FOR PHARMACY

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COMMENT

Is pharmacy in the throes of a love-in with health minister Lord Hunt? It certainly seems so after Monday night's PSNC dinner where both chairman Wally Dove and the minister with responsibility for pharmacy were equally complementary about each other and their respective organisations' constructive dialogue in recent months.

Indeed, it was a dinner that should go down in the history books as the audience frequently applauded or 'hear, heared' rather than showing signs of, at best, indifference, as witnessed in recent years.

Despite the rhetoric, there is much in what Lord Hunt said that fits in with pharmacy's own aspirations. But pharmacy has to deliver. Lord Hunt looks likely to follow through on his promises, so there will have to be a firm commitment and a lot of hard work from the profession. One message that is becoming more apparent is that local working and a local 'contract' will be the trend, so individual pharmacists and individual pharmacies are going to have to pull their weight at a local level. And it is also clear that the minister is expecting pharmacies providing a mediocre service to improve their standards. If not, watch out.

At least one issue that has hindered closer working between pharmacists and GPs is soon to be remedied. Lord Hunt appears to have accepted a joint report on rural issues with recommendations made by PSNC, the GMC and the Dispensing Doctors' Association. Legislation is promised, but how soon? It is essential that such legislation is brought forward promptly now that a deal has been hammered out over doctors' dispensing rights and the Clothier 'loophole'. Otherwise there will be a flurry of applications from both sides trying to take advantage of existing regulations which will only exacerbate the existing problem. Perhaps the minister should be reminded of the last time something like this occurred - how many hundreds of pharmacies were given contracts with the 18 months or so hiatus between the announcement of the intention to bring in control of entry regulations and actually doing so?

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Hunt announces medicines management pilots

The Government is pushing ahead with the key elements in its 'Pharmacy in the Future' programme as fast as it can, was the message from the health minister, Lord Hunt. "We want to take what can be achieved by the best pharmacies and encourage the rest to come up to the same standard," he said.

"If there has been one message that has come through consistently at every PSNC dinner it is that the NHS has historically not made best use of the skills and expertise of the community pharmacist. This year we have set out a programme to put that right".

The Health & Social Services Bill, currently in committee stage, is key to many of the elements of the Pharmacy in the Future programme. It will extend prescribing rights to new groups of professionals. "The pharmacy profession is already gearing itself up to the responsibilities of prescribing," said Lord Hunt.

The Bill will also pave the way for local pharmaceutical services. "This is our new way of contracting for community pharmacy services. This will run alongside the national contract. LPS schemes will not be tied to payment for prescriptions if pharmacists would rather agree to payments for overall quality of services.

"If pharmacists want to combine dispensing with providing a wider range of services, pharmacists and health authorities will be able to negotiate both within a single contract," said the health minister.

"LPS will benefit pharmacists and patients alike by freeing people from rigid agreements and allowing them to experiment with different ways of doing things."

Once the Bill is complete the DoH will look at the national contract. Lord Hunt gave no detail about how this might be revised. "We want terms of service that match today's expectations and that reward quality of service over simple quantity," he said. "We also want to ensure the contract makes pharmacists respond to what patients say they want." He cited private consultation areas. Talking across the counter is not good enough, and this will be increasingly true if pharmacists take on a greater role, he said.

Dr Jim Smith, the new chief pharmacist, has been tasked with taking forward strands of the programme. Empowering patients is key to getting the best use out of medicines, said Lord Hunt. Details of a joint task force on patient partnership in medicines safety will soon be announced.

Dr Smith will also be taking forward the debate on skill mix and making best use of the pharmacy workforce. "This issue needs to be taken seriously," said Lord Hunt. The DoH will be preparing a discussion paper later in the year.

"In pharmacy, as in the rest of the NHS, we need a more flexible working environment and an end to unnecessary demarcation," he said.

"What this will start with in practice is repeat dispensing which will make a big difference to the role of community pharmacists and in the way they are perceived. It is more convenient for patients and gives pharmacists the opportunity to develop their professional skills and reduces the workload on GPs."

By 2004 repeat dispensing will be "scaled up incrementally" to operate on a national basis.

The health minister gave his continued support to the OTC supply of emergency hormonal contraception. "I am glad we won the debate in the House of Lords," he said. I have every confidence in the profession's ability to show that this was the right decision."

Lord Hunt said he believed pharmacy was poised to achieve far more within the NHS. "I know there are many who are fearful about the future, concerned about what they see as a certain fragility in the community pharmacy network. I do not want to give an assurance that nothing will change. What I would say is that, if pharmacy embraces the aims and objectives we have set out, it not only has it a future, but a bright future indeed."

He paid tribute to "the positive and forward looking approach" taken by outgoing PSNC chairman Wally Dove. He had kept an eye on the future, and been instrumental in helping to bring national pharmacy bodies together to focus on opportunities."

Outgoing PSNC chairman Wally Dove confirmed on Monday that his successor has been selected but he was unable to reveal the identity of the person. "We are waiting for the individual concerned to confirm when they are available to start in the post," he said. It is expected an announcement on the chief executive officer will be made after April's meeting

New rural dispensing regulations 'as soon as practicable'

Department of Health lawyers have been asked to translate the agreement reached between PSNC, the GP Committee and dispensing doctors into draft regulations to be laid before Parliament as soon as is practicable

The regulations, covering England, will prevent the establishment of new dispensaries in surgeries already well served by nearby pharmacies, and discourage new pharmacies in small rural communities where they would probably struggle in any case to be viable, said Lord Hunt.

They will also ensure that no application to dispense to patients in rural areas will be granted unless the health authority is sure that it will not prejudice the proper provision of medical or pharmaceutical services to any community.

This will include new GP partnerships formed by the amalgamation of dispensing and non-dispensing practices as well as pharmacists seeking to open additional premises in rural areas.

Rural dispensing has been a long running source of conflict, said Lord Hunt. "It distracts from what primary care should be doing."

The Government has made it clear it would agree to changes in the rules provided both sides agreed. The health minister said the proposals that have come forward from PSNC, the GPC and DDA would benefit both

Hunt gets PSNC seal of approval

There has been more action in the past few months to realise the potential of community pharmacy than there has been in the past 30 years, PSNC chairman Wally Dove told guests at the PSNC dinner on Monday night.

And he praised the health minister Lord Hunt for recognising how much more pharmacists could do, given the political will. "The consensus within our profession is that you're more positive about pharmacy and its potential in the NHS than many in the past," he said.

The Pharmacy in the Future programme goes a long way to matching pharmacists' aspirations. There is at last an opportunity for community pharmacists to extend the range of services they provide. "That does not mean neglecting the things we currently do. It means building on them," he said.

Medicines management will fill a large gap that exists at the moment in primary care. It will reduce unnecessary prescribing and promote concordance. There is widespread support for making medicines management a reality, and it is time to build on that," said Mr Dove.

PSNC's Medicines Management Project Board has agreed on a research team to take its project forward. A consortium led by Aberdeen University, together with Keele and Nottingham Universities, and the College of Pharmacy Practice, has been successful, and will work to set up pilot trials.

"We are very positive about the future for community pharmacy and we want to see many of the ideas set out in your programme of change become a reality," Mr Dove told the health minister.

"But far reaching change needs to be carefully managed, especially in this case. The community pharmacy network is not only very important to the public, it is also very fragile and could easily be damaged."

NHS pharmacists settle pay claim

NHS pharmacists have provisionally settled their pay claim with a two-year pay deal of 3.25 per cent for 2000-01 and 3.7 per cent for 2001-02.

The settlement, announced on March 9, was seen as a significant improvement by the MSF union, representing hospital pharmacists. Besides the increase in salaries, there were similar increases in London weighting for both years, as well as a 3.7 per cent increase in emergency duty commitment responsibility allowance for 2001-02. Back pay and allowances should be received in the March salary.

Pharmacy Alliance gets £10k from Wales

Pharmacy Alliance, UniChem's medicines management division, has won a £10,000 grant from the National Assembly for Wales to fund an osteoporosis project.

This is the first time that the division, which has 812 members, 61 of them in Wales, has been able to tap into national funding. All its medicines management schemes up to now have been developed with support from pharmaceutical companies.

The grant from the Pharmacy Practice Development Scheme will support the project for around three months.

Community pharmacists, using a structured questionnaire, will aim to identify patients at moderate to high risk of developing osteoporosis, and either refer them to their GP or recommend dietary or other measures to treat the condition.

The service will be advertised to customers in participating pharmacies. Pharmacists will be required to brief GPs about what they are doing. Lead pharmacist for the programme is Christopher Martin of St David's Pharmacy, Dyfed. Pharmacy Alliance is currently recruiting pharmacies for the programme.

Pharmacy Alliance managing director Nick England said the Pharmacy Plan, with its support of medicines management, had given the organisation a big boost. Another pharmacist is to be recruited to the head office team soon, bringing the number up to five.

Pharmacy Alliance is talking to a number of primary care organisations about medicines management services. No schemes have been launched yet, but when they are Mr England saidparticipation would be open to any pharmacy locally that meets the criteria.

He has also offered Pharmacy Alliance's services to PSNC as it awaits news of funding for its medicines management scheme from the Department of Health.

Pharmacy Alliance currently has programmes running for asthma and hypertension, and projects under development for chronic pain management, eczema and Parkinson's disease. Mr England said the programmes would eventually be offered on-line through Pharmology.com, UniChem's web service.

£1.9m next years for medicines management pilots

The Department of Health is investing £1.9 million in 2001/02 to support medicines management in 25 pilot sites in England. "We plan to fund more in future years," said the health minister Lord Hunt.

Health authorities, primary care groups, and trusts are this week being invited to be one of the first collaborative sites, which should be up and running later this year.

The pilots will be supported at a national level by a Medicines Management Action team, based at the National Prescribing Centre in Liverpool. Richard Seal, currently at Birmingham Health Authority, has been appointed project director for the action team.

Medicines management is where pharmacists can make a major difference, said Lord Hunt. The pilots would be a major step towards meeting the target set in 'Pharmacy in the Future' of having such services in place nationwide by 2004.

"This gives pharmacists the opportunity as never before to work closely with the primary care team to improve patient care. Even the simplest innovations can make a major difference," he said.

The NHS spends over £5 billion on medicines, and each year drugs worth probably over £100m are returned unused to pharmacies. As many as one in nine households have at least one prescribed medicine no longer being used.

The pilots are likely to range from the simple to the complicated. They could encompass:

- **Patients getting the right medicines in the right quantities and giving advice and support on how to take them**
- **Checking regularly with patients to make sure their medication is effective and is still needed**
- **Managing drug regimes of patients being discharged from hospitals**
- **Medication reviews for those on complicate drug regimens.**

NRT to be available on FP10 by April 30

Nicotine replacement therapy should be available on NHS prescription before the end of April, the Department of Health has announced. In addition it is to proceed with adding certain NRT to the General Sales List.

The announcement, timed for No Smoking Day on March 14, means that the 'black list' will be amended to allow the prescription of the full range of NRT products. This will mean that the following will be prescribable on FP10 forms:

- Nicorette
- Nicorette Plus
- Nicotinell TTS Patches
- Nicabate Nicotine Transdermal Patch
- Nicorette Patch
- Nico Patch
- Nicodex Patch
- Nicostop Patch
- Nicotine Patch (QHR Ltd)
- Niconil Transdermal Patch
- Nicorette Nasal Spray
- Nicotinell Gum

The addition that will be made to the GSL Order will mean that the following will be allowed on general sale:

- Nicotine patches which release a maximum daily dose of 21mg nicotine
- Nicotine lozenges with a maximum strength of 1mg
- Nicotine 4mg gum

Announcing the reasoning behind the GSL amendments, the Department saidthat the Committee on Safety of Medicines advised in December 2000 that some products could be made available and a public consultation was then carried out. "The majority of the responses were in favour including a number of professional bodies such as the Royal College of General Practitioners.

Public health minister Yvette Cooper commented on making NRT available on general sale: "It is absurd that people can buy cigarettes in supermarkets and newsagents but cannot buy patches or gums that they want to help give them up.

"This will mean that the public will have much wider access to these products from supermarkets and general retail outlets. It will improve choice as well as access so that people can find the method of giving up smoking which suits their needs."

However, recent research on smoking cessation services shows that pharmacists' advice significantly improved the chance of smokers stopping. The Queen's University, Belfast, research found that advice given by pharmacists improved the percentage stopping for 12 months from 2 per cent in a group that received no advice to 14.3 per cent in a group that received advice from the pharmacist.

Belfast pharmacist and one of the study's authors, Dr Terry Maguire, commented: "Stopping smoking is not easy and willpower alone won't always work. We have shown that professional advice and nicotine replacement products can make all the difference."

RPSGB's update on diabetes

The Royal Pharmaceutical Society has issued updated diabetes practice guidance to help pharmacists wanting to become more involved in diabetes care.

Based on the guidance issued in September 1999, the new version includes major changes to reflect the national policies on diabetes care for England, Scotland and Wales. It also takes into account the revised diagnostic criteria for diabetes, as recommended by the World Health Organization last year, and contains sections on dealing with teenagers and young people. There is also information on factors such as obesity, smoking cessation and physical exercise.

The Society is advising that pharmacists with an interest in becoming involved in diabetes screening to wait until the national guidance on targeted screening in community pharmacies is approved by Diabetes UK (formerly the British Diabetic Association).

The guidance has been prepared by the Society's diabetes task force with help from the National Pharmaceutical Association and Diabetes UK.

Copies are available free of charge by contacting Angela Canning at the Society's Practice Division (fax 020 7582 3401 or e-mail acanning@rpsgb.org.uk). It can also be downloaded from the Society's website *www.rpsgb.org.uk*.

IN BRIEF

Prescriptions charges up

The Government is to increase the prescription levy by 10p in England taking it to £6.10. The announcement, which was expected to be made after *C&D* went to press, was to be billed as the smallest increase in percentage terms in 20 years, and would come into effect on April 1.

Drug recall

Roche Products Ltd is recalling four batches of its Valium Roche Ampoules (diazepam) 10mg in 2ml. The affected batches are B1013 and B1014, both with expiry October 2003, B1021 with expiry April 2004 and B1026 with expiry August 2004. This is due to stability tests detecting visible particulates in some samples of ampoules over three years old. Further information is available from Roche Customer Services on 0800 731 5711.

Buprenorphine instalment plan

Controlled release buprenorphine will be allowed to be prescribed by instalment for treating drug addiction in England from April 1.

An Amendment Regulation has been made which will allow buprenorphine to be the first Schedule 3 drug under the Misuse of Drugs Regulations to be prescribed on the following prescription forms:

- FP10HP(AD) (pink – hospital outpatient drug misuse instalment forms)
- FP10MDA (blue – drug misuse instalment forms mainly used by GPs)

The Chief Pharmacist's Office has sent out a letter for pharmacists and doctors explaining the change. It points out the only brand of buprenorphine licensed for substitution treatment for opioid dependence is Subutec Sub-Lingual Tablets, so Temgesic should not be supplied on FP10HP(AD) or FP10MDA forms. In addition, the correct patient leaflet should be supplied, so doctors are being asked to prescribe Subutex specifically.

The letter points out that the National Assembly for Wales is planning to introduce a similar change in Regulations, but until this happens, instalment prescriptions for buprenorphine written in England cannot be dispensed by Welsh pharmacies. However, in Scotland, any drug can be dispensed in instalments so no change is required in the Regulations there.

Insulin reminder from Lilly's

The Department of Health is asking health professionals to make sure that patients affected by the change in available insulin formulations be switched to alternatives before their next prescription.

Eli Lilly & Co Ltd is withdrawing a number of its human insulin formulations with a deadline of March 31, which will require certain patients to switch formulation.

While the choice of replacement treatment will rest with the responsible clinicians, the DoH is asking pharmacists to support patients during the changeover and to provide appropriate advice. In the first instance, patients who are on products being withdrawn should be referred to their GP first.

Although the phasing out process started last September, Lilly is concerned that some health professionals may be unaware of the changes. The company has set up a telephone helpline on 0800 0850 777. Information is also given in the Diabetes UK website at: *www.diabetes.org.uk*.

No confidence vote doubts

Taking a no confidence vote in the Council now may not be a good idea, the proposer of the first special general meeting challenging the appointment process for the *Pharmaceutical Journal* editorship has said.

In a statement issued this week, Peter Schofield said: "On balance, we consider that calling a vote of no confidence now is probably not in the best interests of the profession as a whole; ongoing discussions with the Government regarding the future of pharmacy are more important that internecine introspection."

Mr Schofield was the main signatory of the first request for an SGM (*C&D* February 10 p6) with names collected via the Private-Rx website. Although this request for an SGM, which was to ask that the *PJ* editor be a pharmacist, has already been withdrawn, Mr Schofield has revealed that he met Royal Pharmaceutical Society president Christine Glover and secretary and registrar Ann Lewis last month.

At this meeting, he said it was agreed that an informal question and answer session be held on the matter on the same day as the annual general meeting, "but necessarily constitutionally separate". "If in the light of subsequent events this is still useful, then I shall request the Officers to give careful consideration to holding the AGM on a Sunday in order that more members can easily attend," he said.

Mr Schofield says he has also "consulted as widely as possible" since then, and that "the vast majority of pharmacists I have spoken with disagree with the appointment of a non-pharmacist".

"Many are angry," he said. "Many do not understand why, if it was necessary to have an outside influence, this could not have been achieved by consultancy. All are concerned at the apparently intentional obfuscation which surrounded the process."

He was concerned that there is a difference of opinion between himself and the Society's Officers over whether the appointment has been made as a management decision or as a policy decision. He believed that it was a major policy decision and, as such, should have been debated thoroughly by the full Council before ratification.

"Our opinion is that when the proud tradition of 160 years of pharmacist editorship is taken into account, it must be a policy decision, and that the consultation process was flawed and insufficient."

Mr Schofield sees three options – either to proceed with a motion of censure, to proceed with a motion of no confidence, or to have the 'question and answer' session.

"Whilst not underestimating the depth of anger and dissatisfaction felt by many members, the majority believed that a potentially damaging vote of no confidence was not in the best interests of the Society or its members at the moment," he said. "It is fair to report that the expense – both that of members wishing to attend and that which the Society would incur in organising and holding such an event –was a major consideration for many."

Ashwin Tanna, who wants to press ahead with an SGM to discuss a vote of no confidence in the Council for allowing the appointment, also met Miss Lewis on Monday. It was thought likely that the Society is to proceed with an SGM, but it may have to be held after the election for Council.

Mr Schofield acknowledged that Mr Tanna's motion may render a Q&A session irrelevant, but he said that he would wish to keep this option open for the time being. He added: "I wish Ms Olivia Timbs [the new editor] well. I trust she will carry on and improve the proud traditions of the *PJ*."

RPSiS at labour party conference

The Royal Pharmaceutical Society in Scotland has attended its first Scottish political conference, last weekend's Scottish Labour Party conference.

Local pharmacists help RPSiS secretary Dr Sheila Stevens and deputy secretary Findlay Hickey to man a stand at the exhibition, which was visited by several MSPs, including health minister Susan Deacon and Dr Richard Simpson, a member of the Health and Community Care Committee.

Ms Deacon spent about 20 minutes at the stand talking to Dr Stevens, Jackie Agnew, trust chief pharmacist at the Highland Primary Care Trust, and Peter Mutton, interim deputy trust chief pharmacist at the Highland Acute Hospitals NHS Trust.

Other MSPs who visited the stand included: Jackie Baillie, social justice minister, Iain Gray, deputy minister for justice with responsibility for Executive policy in relation to drugs; Henry McLeish, Scottish first minister; and Macolm Chisholm, deputy minister for health and community care.

Pictured on the Royal Pharmaceutical Society in Scotland's stall at the Scottish Labour Party conference are (left) Highland Primary Care Trust chief pharmacist Jackie Agnew and health minister Susan Deacon

All professions to heed competition law

All professions are set to have to abide by the same competition law as other 'industries', including pharmacy, according to the Government.

Trade and industry secretary Stephen Byers said the professions, including accountants, lawyers, surveyors and estate agents, should follow the Competition Act 1998.

While anti-competitive agreements are not permitted under the Act, professional rules are excluded. Pharmacy has been considered a 'trade', which has meant, for example, that the national bodies have been unable to recommend a private prescription price tariff.

"Competition creates pressure to innovate, keep costs down, and improve the quality and choice of products available, and it ensures that resources are allocated to the most efficient firms," said Mr Byers.

The Director General of Fair Trading found that the professions had various restrictions that hampered competition. For example, various ruling bodies have rules that prevent the professions from pooling their resources to create a multi-disciplinary practice.

It is understood that both the Royal Pharmaceutical Society and the National Pharmaceutical Association had written to the DGFT asking that pharmacy be reclassified as a profession, but had been told this was not likely.

Consultation will take place about the restrictions identified by the DGFT, but this latest statement by the government indicates its keenness to remove any 'professional' restrictions which could be seen as anti-competitive.

GP PERSPECTIVE

If you can't win - just dare to be different!

First it was BSE and now it is foot and mouth. Terrible times for British agriculture, terrible times for British farmers. It has been suggested that the root cause of the crisis is the incessant drive for lower prices. Even Tony Blair has questioned the power of the big national grocers to control markets and to drive down prices.

Whatever the rights or wrongs of the debate, economic indicators suggest that consumers are shopping in increasing numbers at supermarkets. Many independent butchers, bakers and grocers have gone bust as the big national chains take more and more of the food market.

"Customers remember quality and service long after they have forgotten the price"

However, a number of specialists remain in business because they provide a first class service and in many cases dare to be different. Not everyone is driven by price.

It has been said that medicines are not ordinary items of commerce. If resale price maintenance is abolished, OTC medicines will rapidly become ordinary items of commerce and the supermarkets and certain multiple pharmacy groups will lead the charge.

The indications are that there will be promotions and price reductions aimed at capturing additional market share. There will be a deal of early noise and activity but after the initial excitement the market will settle and the normal laws of supply and demand will be established - or will they?

How many small pharmacies will find the going too tough and go out of business? Will the healthcare needs of the public be better served because of cheap medicines? Where will it all end? Cheap food prices seemed a wonderful idea, but judging by recent events, the cost is too high.

A thought for all community pharmacies when it comes to price: you can't beat them, so don't join them. Be different, specialise. Customers remember quality and service long after they have forgotten the price.

Written by a senior industry manager

Xrayser

Topical Reflections

The DoH looks at costs, and so do I!

I regret that I was not invited to the recent British Association of Pharmaceutical Wholesalers conference, but the omission is understandable as I am not a wholesaler. Nevertheless the opportunity to hear and question Richard Cienciala, a civil servant at the Department of Health, would have been welcome.

According to Mr Cienciala (and I assume he was not talking out of turn) the DoH is concerned that the current Drug Tariff system, designed to reimburse community pharmacists for their costs, should be more vigorously enforced and that ways of reducing supply side profit are being investigated.

If I were making overall excess profits from my NHS activities I would be sympathetic to this view but I am not. The cost of running my business also affects my overall remuneration and these costs are now cynically ignored by the DoH.

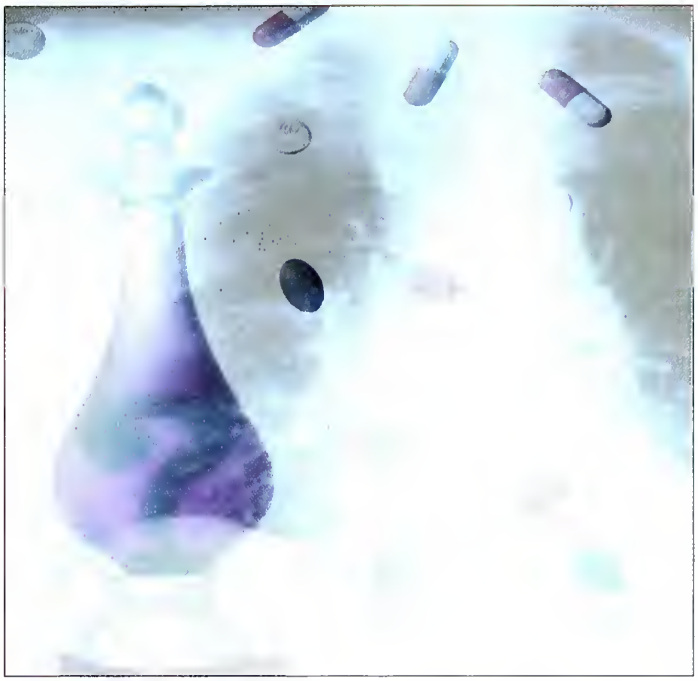
Under the old cost-plus contract I was reimbursed on a global averaging basis for all the costs incurred in providing NHS service and this included time, staff and overhead expenses. The changes to these overheads, necessary to meet the increasing challenge of improved NHS pharmaceutical service, were calculated by financial sampling and applied to the annual global sum calculation.

It was a reasonable system, even taking the blunt instrument of averaging into account, but the government took fright at increasing costs and unilaterally changed to imposed settlements. Since then, successive administrations have forced efficiencies through year-on-year low increases to the global sum.

But I still have to pay my overheads and I would challenge the financial gurus at the DoH to go through my business accounts, apportion the value of my contribution to NHS patient care, and then tell me whether I really am making excess profit.

The DoH cannot be allowed to have its cake and eat it. If the Department wishes to enforce drug cost reimbursement more vigorously, then I want a reciprocal arrangement - full reimbursement of the actual cost of running my NHS practice.

That is the proposition I would have liked to put to Mr Cienciala and that is the problem that the DoH refuses to address openly.



Don't be defensive when giving advice on EHC

The demand for emergency hormonal contraception has been far less than I expected, and I have had ample time to attend the excellent CPPE workshop and study its comprehensive information booklet.

In fact, the demand only materialised this week, when a young lady who had missed taking her oral contraceptive pill asked for help. I gathered my thoughts and started the sympathetic inquisition.

Yes, after the first few questions that was what I felt I was doing. In response to the attacks on professional integrity by the media I was subconsciously adopting a defensive questioning technique.

But here was a young lady asking for my professional help and my first response was to look to my own protection. Not a very professional attitude, and I quickly changed to the more empathetic technique she deserved.

At the end of the quite short consultation I was happy to supply EHC and pleased that this young lady had wanted my confidential advice. I was delighted at the outcome and annoyed that I had been trapped into practising defensive pharmacy.

The supply of EHC should be no different to the sale of any other Pharmacy medicine under protocol, and should be approached in a positive manner designed to reinforce the client's opinion that it was right to seek the advice of a pharmacist.

Red herring from Dupont

I have just received a strange letter from DuPont Pharmaceuticals announcing a new pricing structure for Carace and explaining how I would benefit by using Carace against open prescriptions for lisinopril.

I have always dispensed Zestril since that is what the Tariff price has been based upon, but now DuPont has dropped the price of Carace below Tariff and said that I will benefit accordingly.

But surely this is a red herring because the Tariff should now adjust to the changed market competition and, meanwhile, what will AstraZeneca do? Nothing?

LPCs rejected an end to POD checks and a PSNC/NPA merger at this year's Local Pharmaceutical Committee conference held in London on Monday

Like 2p in the POD

The Local Pharmaceutical Committee conference has rejected calls to withdraw from point of dispensing checks.

Liverpool LPC proposed a resolution urging PSNC to give back the £13 million allocated to the global sum for exemption checking, with the message: "Do it yourself, we want nothing more to do with POD checks."

Proposing, Hassan Argomandkhah calculated that contractors were losing £30m a year by the transfer of items from 'exempt' to 'paid' bundles of prescriptions. "That means they take back – or fine us – almost three times as much as they are paying us. The scale of the injustice is staggering."

Hassan Argomandkhah

Seconding, Jeremy Clitherow said: "This is real money we're losing. It is not just yet another item of service for a trivial fee, the reality is a harsh financial penalty."

St Helens and Knowsley LPC wanted to withdraw from the POD arrangements until a new agreement, acceptable to all contractors, could be negotiated.

Chris Williams spoke of the abuse pharmacists received from patients when asked for evidence of exemption, which ranged from "I could die without my tablets and it would be your fault" to "Give me my prescription back, I'm not coming here again".

He asked: "Who is most likely to be called out at 2am because a brick has been thrown through the pharmacy window? You've guessed! And all for two pence an item."

He said contractors would never have agreed to the present system if they had realised it would lead to prescription switching and financial penalties. It was grossly unfair that contractors had no automatic right to claim what was theirs.

"It's not that we don't support the concept of POD checks but it's the means of implementation that's wrong," he said.

Earlier PSNC chairman Wally Dove advised contractors not to stop the checks. He said PSNC had built up a good relationship with Jim Gee, director of counter-fraud services, who was well disposed to pharmacists because of their "success story" in tackling fraudulent behaviour. Mr Gee was an important and influential ally at the Department.

"He is also someone with access to significant budgets and the ears of Ministers," he said. "He believes – and his views reflect those of Ministers – that savings generated by POD checks should in part be ploughed back into community pharmacy. My hope is that we will shortly see how those savings might be used to our benefit. But our access to that pool of money depends on us carrying out our POD checks thoroughly and effectively."

Mr Dove pointed out that switching had been happening long before POD checks, but the checks had brought to light the large numbers of prescriptions involved.

"We're doing our best to sort out the problem ... but please don't rubbish POD checks," he said.

PSNC general secretary Stephen Axon said the Prescription Pricing Authority claimed to make few errors with the switches. A check by the PPA's quality assurance department showed accuracy of well over 99 per cent in each of the three months investigated. But if contractors had evidence to the contrary, PSNC would be happy to take up the matter with the PPA, he said.

The two resolutions were lost, but the meeting voted in favour of another from Manchester LPC urging PSNC to negotiate a realistic fee for the checks.

PNSC/NPA merger

Delegates voted against PSNC considering and discussing the possibility of a merger with the National Pharmaceutical Association.

The Leicestershire and Warwickshire LPCs' motion argued that such a move would be "in the interests of a stronger, more cost-effective and efficient pharmacy voice".

Proposer Simon Davis argued that community pharmacy would be more effectively served by one body as there are too many organisations representing pharmacy, causing confusion. In turn, this allowed the Government to play one organisation off against the other. Instead, he said: "It's essential that we maintain a clear and consistent position."

A merger would end duplication of effort and a waste of costs in such areas as human resources or IT. Economies of scale would mean that members could obtain services at lower costs and allow more investment in pharmacy services.

Mr Davis recognised that such a merger would not be a straight forward process; the resultant body would have to speak for all community pharmacies, and the impact of devolution would have to be addressed. But overall, the resultant single committee would reduce costs, speed decision making and represent a unified voice to outsiders.

Arguing against the motion, Dr Hopkin Maddock, Cornwall, said that a PSNC/NPA merger which did not include the Company Chemists Association could mean that there would be two bodies negotiating over two different contracts with the Government. "The economies of scale are obvious, but only if the three join, and not the two," he said.

Malcolm Goldie, Gateshead and South Tyneside LPC, questioned what advantage there could be in taking a specialist organisation, PSNC, and subsuming it in the generalist organisation of the NPA.

NPA chairman Ben Zatland said that the Board has seen the paper which initially proposed the merger, but has not debated it. "At present, my view is that there is a need for long and detailed discussion before anything of this nature is considered. If such a thing is ever contemplated, the NPA will ensure that there will be a consultation with all parties involved".

Imran Khan

Imran Khan, from Redbridge and Waltham Forest, argued for the status quo. "PSNC has a job to do and they are doing it," he said. "We do need a specialist body to do the negotiation and you cannot have a subcommittee of another body doing this. Now is not the time to tinker with the system."

Ashok Soni, Lambeth, Southwark & Lewisham, said that the motion suggests that pharmacists have failed to get their message across to the Government, but having a merger would not change that. Instead, he called for communication within the profession to reach a common agenda.

Delegates backed a resolution calling for primary care groups to act more even-handedly when disbursing

Continued on P10 →

The conference supported a resolution put by Richard Evans (right) and John Llewelyn, Dyfed Powys, deploring the fact that year after year contractors received no recognition for increased productivity. Mr Llewelyn said that pharmacists were rewarded for savings to the drugs bill by an annual "kick in the teeth"

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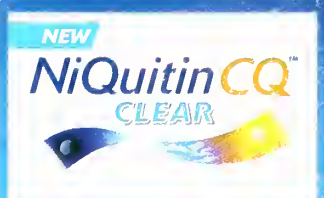

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→Continued from P8

David Kent

funds available to them. David Kent from Camden & Islington LPC, described ways of "creative accounting" that prevented pharmacy getting a fair share of payments, which went mostly to GPs. Pharmacists co-opted to PCG boards had reported feeling like a spare part at meetings, or that their input was not welcome.

Margaret Hook, Avon, thought secondary care was regarded as a higher priority because of the demand to reduce waiting lists and it had been difficult for community pharmacists to get continued funding after pilot studies. She suggested that pharmacists had to work collaboratively with other team members, to address their needs and win them over.

But other contractors spoke positively about what they had achieved. Graham Phillips, West Herts, reported progress in working with local doctors, while Mr Khan said his contractors had gained over £1m for medicines management in his area. "We've got to learn to market our services," he said.

Dr Maddock said his LPC had prepared a detailed strategy based on 'Pharmacy in the future' and the health authority had agreed to take up certain matters. Contractors also hoped to have meetings with PCG chief executives.

The conference strongly supported a Redbridge & Waltham Forest motion calling on PSNC to work with the Guild of Healthcare Pharmacists and the Department of Health to develop an integrated strategy for patients discharged from hospital.

Saying that clear arrangements between community and hospital pharmacy will be what the future of the healthcare is about, proposer Imran Khan pointed out that Health Minister Lord Hunt has made it clear that those pharmacists willing to provide more than just the standard service will be rewarded at the expense of others.

"PSNC needs to sit down with the DoH and the GHP and create an integrated strategy," he said. A properly coordinated service will give a total package that would meet the expectation of patients that those providing their care actually talk to each other.

Other benefits would be that other health professionals in primary and secondary settings would be encouraged to work together and there would be improved patient care. "This is crucial to where we want to be," he said. "We want to be right at the hub of the wheel. We have the talent to do it, the skills and the commitment."

A motion calling on PSNC to recognise that supervising the dispensing of drugs and the provision of appropriate related advice would remain the principal task of community pharmacists for the foreseeable future was carried after changing 'principal task' to 'responsibility'.

Proposing the original motion, Philip Quinlan of North Yorkshire LPC argued that pharmacists are remunerated only for dispensing medicines and the advice that goes with that. If dispensing were delegated to those who have no history of doing it safely, and if they then let the pharmacist down, who would be picked up on this?

Speaking for the amended motion, Malcolm Goldie said it was important for pharmacists to retain the responsibility for such tasks, although not the actual work.

Other resolutions carried

- PSNC should negotiate a national scheme for prescribing, particularly emergency contraception, from community pharmacies.
- Arrangements should be made so that essential small pharmacies receive payments on top of the ESPS fee for prescriptions marked urgent.
- PSNC should develop a public health strategy for pharmacy.

A call for the model constitution of LPCs to be amended so that LPC secretaries would be called chief executive was lost. Proposer Robert Curd of Ealing Hounslow and Hammersmith LPC said that the title LPC secretary was not being recognised by many people entering into the healthcare arena with the establishment of the many new NHS bodies and organisations. Hence, he said, there was a need for a less 'old fashioned' title which would reflect the important role that LPC secretaries carry out for contractors, as more people would be likely to respond to correspondence from a chief executive than secretary.

Arguments against the motion were that a title like chief executive carries many connotations and could confer too much responsibility on the person.

Minister accepts rural dispensing plans

Health minister Lord Hunt has accepted proposals from doctors and pharmacists for new legislation controlling dispensing in rural areas.

Despite some extremely difficult issues, the Pharmaceutical Services Negotiating Committee, the GP Committee, and Dispensing Doctors Association agreed on a modified package of changes, which they took to the minister in January.

"The good news is that the minister accepted our proposals and expressed his strong wish to see them brought into law as quickly as possible," PSNC chairman Wally Dove told the LPC conference. Getting the minister's acceptance was by no means guaranteed as he was politically wary of backing the initiative.

Mr Dove said the package would permanently remove the threat of doctor dispensing in market towns and the vast majority of rural situations. They would provide for stability, encourage better working relationships between rural GPs and pharmacists, and ensure that, wherever possible, patients would have the right to access a proper pharmaceutical service from a pharmacy.

Turning to the Government's pharmacy programme, Mr Dove said: "This is the biggest programme of change to be presented to us in living memory perhaps in the history of our profession. It would be surprising if it didn't contain some things that worried us."

But PSNC has had several discussions with ministers and senior civil servants, seeking reassurance that they are not trying to damage the vital, but fragile, resource of community pharmacy.

"They know they need to manage the change process carefully if it is to succeed," he said. "That means moving at a modest speed, and consulting all the way with us and with others. It means recognising not just what is desirable, but what is practically achievable."

His impression was that Lord Hunt and his senior officials did not intend to undermine or by-pass community pharmacy. "They need us with them, not against them. Their programme simply won't happen without community pharmacy's involvement.

"They are quick to reassure us they have no intention of damaging the community pharmacy network. They have also reassured us that good providers of good quality services will be properly rewarded, and will have nothing to fear. By implication, those who fall short of quality standards will fare less well. That is as it should be. I don't think PSNC should be seeking to defend poor quality, low level services."

Usually, the PSNC chairman reports to the LPC conference on the current state of remuneration negotiations. But Mr Dove said this is not a normal year and PSNC is still awaiting proposals for a new national contract as outlined in 'Pharmacy in the future'.

"When they appear, we will work with [the Department] to refine and agree ideas that are fair and reasonable, and which give contractors the chance to be properly rewarded for providing a growing range of pharmaceutical services. We will not agree to something that further undervalues dispensing, or that is likely to lead to community pharmacies closing and services becoming less accessible."

He expected that discussions would not start until after the general election, but contractors should not be too worried about the delay.

The results of the discount inquiry, which started last October, are not yet available but they will apply from October 1, 2000, and any change to the clawback will reflect the downward shift in generic prices since last spring.

The firm of economists (OXERA) reviewing generics supply has presented its findings privately to the Department, but PSNC knows roughly the proposed options, which are continuation of maximum prices, a PPRS approach, reference prices and central purchasing. The Department is expected to produce a consultation paper on the proposals soon.

PSNC believes each option holds major problems. But if the maximum prices system continues to work reasonably well, it may be the most sensible option for the longer term.

Turning to the Health and Social Care Bill, Mr Dove said one by-product was that LPCs and PSNC would have to make constitutional changes to ensure they represented all local providers of pharmaceutical services, not just contractors. PSNC intends to address the issue in coming weeks and will be consulting on any changes.

Launch of development programme

The LPC conference saw the official launch of PSNC's Community Pharmacy Development Programme, backed by sponsorship from a range of companies.

Five companies have agreed to pay £25,000 a year to work in partnership with PSNC in promoting and developing community pharmacy in the NHS. PSNC will use the money to develop the services it provides to LPCs and contractors, such as training resources, the community pharmacy database, public relations, parliamentary activity and promoting the pharmacist's role in medicines management.

For the first year, PSNC will be working with APS Berk, AstraZeneca, Boehringer Ingelheim, GlaxoSmithKline and Norton Healthcare.

In return, the companies will have an exhibition stand at the LPC conference and other publicity. But chairman Wally Dove stressed that the companies would not be able to tell PSNC what to do, nor would PSNC be dependent on their investment for running its core services.

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Medical matters

IN BRIEF

Tritace 2.5mg in small packs

Aventis Pharma has introduced a new 7-capsule pack of Tritace (ramipril) 2.5mg, to complement the existing 28-capsule pack. The basic NHS price for the new pack is £1.88.

Aventis Pharma Ltd.
Tel: 0990 133347.

Drisorb dressing on NHS

Drisorb Sterile Wound Pad 10cmx20cm will be included on the Drug Tariff from April. The pads are designed for use as a primary dressing in low exudates wounds, or as a secondary, cushioning dressing for heavily exudating wounds. The dressings will be packed individually and will come in bags of 25 (basic NHS price 17p per pad).

Vernon-Carus Ltd.
Tel: 01772 744493.

Generics UK additions

Trazodone Capsules 50mg (84, £17.31) and 100mg (56, £20.38), and Co-Codamol Tablets (100, £1.65) have been added to Generics UK's portfolio of drugs.

Generics UK Ltd.
Tel: 01707 853000.

No 'black triangle' for Seroquel

The special 'black triangle' classification for Seroquel Tablets (quetiapine) has now been removed. In addition, the shelf life of Arimidex Tablets (anastrozole) has been extended from three to five years, and that of Plendil 2.5mg Tablets (felodipine) has been reduced from three years to 18 months.

AstraZeneca UK Ltd.
Tel: 01923 266191.

NICE issues guidance on orlistat and pioglitazone

The National Institute for Clinical Excellence (NICE) has issued new guidance on the use of orlistat (Xenical) in obesity and on the prescribing of pioglitazone (Actos) in type 2 diabetes.

Orlistat can now be prescribed on the NHS as part of the management regimen for obesity. Adult patients have to fulfil the following criteria:

- they must have lost at least 2.5kg through diet or exercise in the month before the drug is prescribed
- they must have a body mass index (BMI) of at least 28kg/m^2 and have another serious illness which persists despite standard treatment; or a BMI of 30kg/m^2 or more and no associated illness
- therapy should only be continued beyond three months if the patient has lost at least 5 per cent of their body weight since starting orlistat, and only continued beyond six months if at least 10 per cent of body weight has been lost
- treatment should not normally be continued beyond 12 months, and never beyond 24 months.

The advice on the use of pioglitazone in type 2 diabetes is that it should be offered as combination therapy and as an alternative to injected insulin if:

- patients cannot take metformin and sulphonylureas as a combination therapy, or
- their blood glucose levels are not controlled and remain high while they are on this combination therapy.

The latest recommendations on pioglitazone follow guidelines issued last year on rosiglitazone (Avandia), another thiazolidinedione targeting insulin resistance. NICE is now recommending both drugs as alternative therapies in type 2 diabetes.

Full guidelines on orlistat and pioglitazone can be obtained on *www.nice.org.uk*

- NICE has confirmed the next wave of treatments that are going to be appraised. These include the ovarian cancer drug Caelyx, early initiation of 'clot-busting' drugs for heart attacks and STI-571 for chronic myeloid leukaemia.

Nicotine withdrawal experienced by smokers and quitters

Smokers experience the same withdrawal symptoms between cigarettes as people trying to give up smoking completely.

New research suggests that two-thirds of smokers experience the symptoms of giving up as often as 15 times a day. The withdrawal symptoms are experienced at times in the day when the urge takes them but they are unable to reach out for a cigarette - at work, for example, or in restaurants.

The withdrawal symptoms kick in when nicotine levels fall below a certain threshold. The more cigarettes someone smokes, the quicker these levels fall and the quicker the onset of withdrawal symptoms. These include cravings, irritability, lack of concentration and restlessness.

Now smoking cessation experts are urging smokers to go a step further and give up completely rather than subject themselves to repeated and unplanned episodes of withdrawal. Smoking cessation expert Professor Godfrey Fowler says: "Withdrawal pangs are not only an indication of nicotine withdrawal, but also a sign that the body is starting to repair itself. Very soon after your last cigarette your heart, blood circulation and lungs are rid of dangerous chemicals and start to work more effectively."

In the research conducted on behalf of Nicotinell, 15 per cent of smokers said they only smoked in the evenings which meant that carbon monoxide and nicotine levels in the blood had dropped and oxygen levels had risen and returned to normal.

National No Smoking Day was on March 14.

Zanamivir inhaler 'needs improvement'

The inhaler used in delivering the influenza drug zanamivir needs to be improved, say researchers at the Mayday Hospital in Croydon.

The team found that elderly patients in the study were unable to use the Diskhaler that is used to deliver zanamivir. As a result, treatment with the drug was unlikely to be effective in this group of patients, unless the delivery device is improved.

The study, published in the *British Medical Journal*, gave one group of patients the Diskhaler to deliver zanamivir, and another the Turbohaler. The inhalers differed in terms of their loading and priming techniques. After counselling, half of the patients allocated the Diskhaler were unable to load and prime the device and 65 per cent still could not manage it 24 hours later. With the Turbohaler, only two patients from the sample of 35 had problems with the device, and after 24 hours this dropped to only one.

The researchers conclude that the current zanamivir delivery device needs reviewing, bearing in mind the elderly who are prime candidates for the treatment. Particular attention should be paid to the loading and priming of the device.

Femoston 1/10 licence for osteoporosis

Femoston 1/10 has had its licence extended to include use in the prevention of osteoporosis.

Femoston 1/10 is the first low dose sequential hormone replacement therapy containing oestradiol 1mg to receive such a licence in the UK. The HRT also contains dydrogesterone 10mg.

Solvay Healthcare's other HRT product, Femoston-conti, is licensed for the prevention of osteoporosis in women who are either 12 months postmenopause or who are aged 54 years or older.

Solvay Healthcare Ltd.
Tel: 02380 467000.

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PRECAUTIONS: Do not exceed recommended dose, particularly if driving or operating machinery.
DRUG INTERACTIONS: To date there are no known interactions with other drugs. As with other antihistamines avoid excessive alcohol consumption.
SIDE EFFECTS: Mild and transient drowsiness, headache, dizziness, agitation, dry mouth and gastrointestinal discomfort have been reported.
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PRODUCT LICENCE NUMBER: Tablets 08972/0032.

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* IMS HEALTH MIDAS data. Unit sales. July 1999 - June 2000
Date of preparation: January 2001
UCB-Z-01-03

ucb Pharma

Counterpoints

Women's herb may help PMS symptoms

SwissHealth has developed a herbal supplement to relieve the symptoms of PMS. Herbal Premens is a daily supplement that contains 40mg of the standardised whole extract of the chaste tree.

It is believed that this ingredient acts as a stimulant to the pituitary gland, redressing the hormonal balance before a woman's period.

Retail price is £6.99 for one month's supply.

Trinity Sales and Marketing.
Tel: 01753 864455.

Kira's liquid assets

Kira has developed a St John's Wort liquid herbal extract for those people who prefer tinctures to tablets. Twenty drops of Kira St John's Wort liquid herbal extract LI-160 provide the same dosage as Kira Original tablets.

St John's Wort is used to help relieve symptoms of depression, Seasonal Affective Disorder (SAD) and pre-menstrual syndrome.

Food Brokers.
Tel: 02392 222500.

UniChem range offers pharmacies sunny profits

UniChem is relaunching its suncare range to drive sales in pharmacies. The four UniChem suncare lotions (SPF 4, 8, 15 and 25) have been reformulated to provide four star-UVA protection.

New packaging for the lotions and an After Sun features an easy-to-use 'less mess' bottle design.

Posters, consumer leaflets and shelf talkers are available free to pharmacies.

Retail prices start at £2.29. Pharmacies can take advantage of up to 60 per cent profit on return until the end of April.

The range is also available as 'splits' with a next-day delivery enabling pharmacists to take advantage of any unpredictable weather patterns such as sudden heat waves.

UniChem Ltd.
Tel: 020 8391 2323.

Year round message for Rhinolast Allergy

AHA Sales Services is relaunching its Rhinolast Hayfever nasal spray as Rhinolast Allergy to convey the 'year round allergy relief' message to consumers.

Rhinolast Allergy, which contains 0.1 per cent azelastine hydrochloride, is indicated for the relief of perennial allergic rhinitis.

Recent changes to the product licence now indicate that azelastine is effective in treating perennial allergic rhinitis caused not only by pollen, but also dust mites, mould spores and animal dander.

Rhinolast Allergy can be administered to adults, the elderly and children over five. Rhinolast was previously only available for use in those over 12 years, but has now been shown to be effective for children aged five and over.

The recommended dosage is one spray in each nostril, morning and evening.

A press advertising campaign will support the brand this year.

AHA Sales Services Ltd.
Tel: 01491 833202.

Families can keep mozzies at bay

Ardern Healthcare is adding a standard-strength DEET insect repellent to its Ben's range.

Ben's 30 Standard Strength is a 30 per cent DEET repellent, formulated to provide up to eight hours protection against biting insects.

Because the product is formulated in water, rather than alcohol, it evaporates more slowly and does not need to be applied so often.

It comes in a controlled flow applicator, designed for precise application to the face and neck without getting on the hands.

The product is suitable for general family use, apart from infants.

Retail price is £4.99 for 59ml.

Ben's 100 DEET for maximum protection and new Ben's 30 are packaged on eye-catching orange showcards with comprehensive guidance on product suitability for individual needs.

Ardern Healthcare Ltd.
Tel: 01584 781777.

Covonia brand is all bottled up

Thornton & Ross is repackaging its Covonia range of cough medicines.

An eye-catching new bottle is being introduced for Original Covonia Bronchial Balsam, Covonia Mentholated Cough Mixture and Covonia Night-time Formula.

Covonia branding is embossed on the new bottles which are designed to retain the brand's traditional values.

The medicines are presented in the bottles without cartons to give them a point of difference on shelf.

The information label on the back of the bottles has been updated to make it more 'user friendly' for customers.

Thornton & Ross.
Tel: 01484 842217.

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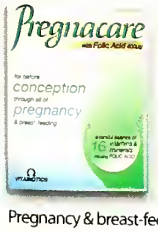

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Osteocare® is the UK's leading calcium supplement, and is more advanced with additional bone-strengthening nutrients like boron and copper. Modern new packaging highlights Osteocare's support of the *National Osteoporosis Society*, and we'll be making sure it's leaping off your shelves too, with a major new advertising campaign featuring the *English National Ballet*.

Perfectil® advances your customer's beauty regime with a unique combination that's recommended by *Premier* –z the leading model agency representing some of the biggest international stars of the business.

Wellman® has been boosted with stylish new packaging, and is the choice of many professional sports teams including *Premier League* football clubs. It's ideal for sportsmen and executives with a hectic lifestyle.

Wellwoman® has been launched in conjunction with *She magazine* and both Cardioace and Jointace are now approved by *BUPA*.

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www.vitabiotics.com

Scholl advances in foot odour battle

SSL International is introducing new odour-neutralising technology into its Scholl Odour Control range of foot and shoe sprays.

Veilex technology has been developed to increase effectiveness by counteracting and neutralising odour, rather than simply masking it.

The Scholl range includes Odour Control Foot Spray (rsp £2.99), which offers 24-hour protection against odour, and Odour Control Shower Spray (rsp £2.99) with antibacterial and antifungal action.

SSL International plc.
Tel: 0161 654 3000.

Triple-blade throw-away razor

Sterling Four is launching a disposable triple-blade razor into the UK men's shaving market this month.

Super-Max 3 is manufactured in India and was successfully launched in the US last summer. Sterling Four aims to encourage disposable razor users to trade up to a premium disposable razor.

The razor has been developed to provide a quick, close and clean shave. It has a long, blue handle, designed for an easy grip, and a 'naturestrip' containing tea tree oil.

The packaging is a bright blue box, with a razor holder to keep razors stored neatly and safely before and after use.

The launch will be supported by a £2 million marketing campaign with the theme 'the first disposable to do the treble'.

The campaign will include press advertising starting in June, a TV campaign scheduled for the autumn and direct mail activity.

A female version of the razor will be launched on April 23. The women's razor will have a green handle, lilac packaging, and a 'naturestrip' with aloe vera, vitamin E and tea tree oil.

Both the men's and women's razors will retail at £2.49 for a pack of four. The men's razors are also available in an eight pack (rsp £4.25).

In addition, Super Max shave foam is being introduced in three variants - menthol, classic and sensitive (rsp £1.39 for 300ml).

Sterling Four.
Tel: 020 8844 1433.

What you see is what you'll be

Chefaro Proprietaries is supporting its Predictor pregnancy test with a £1 million TV and press campaign starting on March 19.

The advertising is designed to raise awareness of the recently modified pregnancy test and make it more appealing to a younger audience. The TV commercial features two friends - one of whom keeps putting off actually looking at the test result. The copyline 'what you see is what you'll be' is designed to convey the brand's new 'greater reassurance' message.

Predictor features an extra check window to confirm that the result is definite and will not change over time, eliminating doubt over the final result.

Chefaro Proprietaries Ltd.
Tel: 01480 421800.

ON TV NEXT WEEK

Avent Magic Cup: GMTV, Sat
Clearasil: ITV, C4, Sat
Dove Body Moisturiser & Body Silk: All areas
E45 and Skin Confidence E45: All areas except LWT, GMTV, TSW
Feminax: All areas
Ibuleve maximum strength: C4
Imodium Plus: U, STV, HTV, W, LWT, CAR, C4, C5
Imperial Leather dancing duck: All areas
Kalms: C5
Listerine: All areas
Macleans whitening toothpaste: All areas
Movelat Relief: C4, C5
Nicorette: All areas
NiQuitin CQ: All areas except GTV, U, Y, CTV, CAR, TT, TSW
NiQuitin CQ clear: U
Nytol: All areas
Otex: C4
Oxy: Sat
Predictor: C4, GMTV, Sat
Propain: C4, C5
Regaine: GTV, U, STV, B, G, Y, C, A, M, LWT
Simple: All areas
Solpadeine: STV, B, G, C, HTV
Pharmasite for next week: Nicorette Gum – Window. **Nicorette Inhalator** – In-store. **Nicorette Patch** – Dispensary

A Anglia, **B** Border, **C** Central, **C4** Channel 4, **C5** Channel 5, **CAR** Carlton, **CTV** Channel Islands, **G** Granada, **GMTV** Breakfast Television, **GTV** Grampian, **HTV** Wales & West, **LWT** London Weekend, **M** Meridian, **Sat** Satellite, **STV** Scotland (central), **TT** Tyne Tees, **U** Ulster, **W** Westcountry, **Y** Yorkshire

Venus makes a £15m mark

Gillette is investing £15 million in a marketing package for its new women's system razor, Gillette for Women Venus.

Advertising begins on April 4 with a poster campaign, which opens with a 'teaser' image. This is followed a week later by a second, explanatory image which coincides with the start of a major TV campaign.

TV commercials will be on air between April and July, with prime slots in the break during Coronation Street.

Other marketing areas include the Internet, with a dedicated Venus web site, and banners and sponsorship on key women's sites.

More than 2,000 liveried buses will carry Venus advertising and there is a full range of PoS material, plus planograms and merchandising advice.

With an estimated 55 per cent of women still shaving with men's disposable razors, Gillette aims to encourage new users to the women's market and to prompt current users of women's disposables to trade up to a system shaver.

The market is expected to grow by £47 million between now and 2003 and Gillette predicts that Venus will contribute £43m of this growth.

Venus comes with its own shower storage system, which keeps refill blades dry. It retails at £5.49 for the razor, storage compact, one live and one spare cartridge, and £5.99 for a pack of four refill cartridges.

Gillette UK Ltd.
Tel: 020 8560 1234.

Dove campaign smoothes the way

Lever Fabergé is supporting its Dove Body Moisturiser & Dove Body Silk with a £4 million twin campaign.

A TV commercial for Dove Body Silk is on air this month, with additional advertising planned throughout the spring. The campaign communicates the brand proposition 'feeling of silk all over'.

Dove Body Moisturiser will be supported by bursts of TV advertising until the end of June. The commercial is aimed at women with busy lifestyles who want to take care of their skin.

A series of press advertising for both products will appear in the women's press until July.

Dove Body Silk sampling activity will run in store as well as via the press and direct mail.

Dove Ultra Moisturising Mousse will be supported by a £1.5 million campaign that includes national radio and poster advertising until the end of June.

Lever Fabergé.
Tel: 020 8481 6000.

MARKETWATCH

Market analyst Information Resources reports on how sales of OTC medicines are performing in pharmacies

From small beginnings...

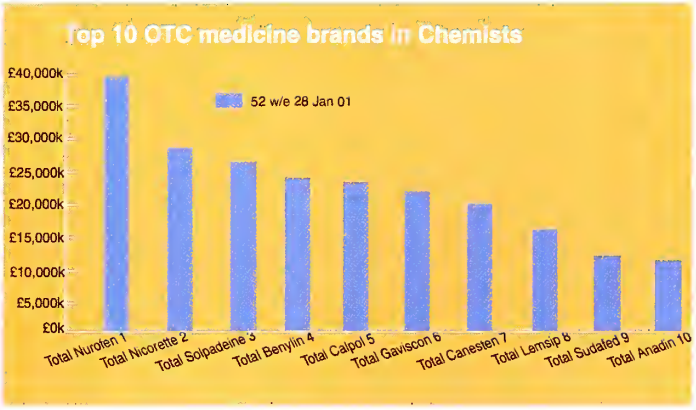
OTC sales continue to grow within pharmacies (including Boots the Chemists), though more gradually in the latest 52 weeks, with total sales up just 0.6 per cent.

The highest growth is in the smaller categories, including laxatives (+9.5 per cent), anti-haemorrhoids (+7.7per cent), hayfever remedies (+6.6 per cent) and sleeping aids (+6.3 per cent).

Laxatives (£30.8 million) is in the top slot and is showing great potential. Reckitt Benckiser can claim first and second place in this market with its brands Senokot and Fybogel.

Both products are performing well, with annual sales growth of around +17 per cent each. Dulcolax from Boehringer Ingelheim takes third place, also showing impressive growth of +7.1 per cent.

Hayfever remedies also prospered in the last 12 months, with all the top brands showing healthy growth and driving category sales. Piriton from Stafford Miller (+10.7 per cent) takes the coveted number one slot, followed closely by Warner Lambert's two products Benadryl (+5.2 per cent) and Beconase (+2.3 per cent).



Sleep on it

Sleeping aids is another growth area. A good night's sleep is often seen as critical to daytime performance, but with increasingly demanding working hours and hectic social schedules, people are left feeling stressed, restless and unable to sleep.

The decision to use sleeping aids is not one that should be taken lightly, and it is likely that a large proportion of those considering their use would rather consult their local pharmacist for friendly advice and guidance.

The £11.3m market is dominated by the Nytol brand, with two variants accounting for over 90per cent of the market. Nytol One-A-Night grew by +11.9 per cent in the last year.

The category has seen only one significant product introduction in the last year, in the form of Dreemon from Peach Pharmaceuticals.

Indigestion remedies are growing strongly, up 4.7 per cent. Data suggests that this growth may be at the expense of the stomach upset remedies, with category sales down 6.0 per cent.

Strong sales

Indigestion remedies such as Rennie (+ 6.4 per cent), Gaviscon (+11.5 per cent) and Zantac (+29.4 per cent) have all benefited from strong category sales, but sales of stomach upset remedies such as Resolve, Alka Seltzer and Andrews Salts have fallen.

Whether or not this activity is related to consumers switching between categories and brands, it is worth noting that last Christmas, Rennie (indigestion remedies) replaced Alka Seltzer (stomach upset remedies) in the prime advertising slot, sponsoring all the major films on ITV. This seems to have benefited Rennie and raised awareness for the category.

Looking briefly at the categories that are in decline, cynics might point a finger at the multiple grocers, arguing that they continue to steal both sales and share.

While grocers may be partly to blame, total market level performance mirrors activity within pharmacies suggesting another variable is involved.

Wet 'n' warm

Another explanation could be the weather. The two peak winter months, December 2000 and January 2001, were warmer and wetter, implying less demand for products that usually prosper during the cold.

Annual sales of cold and flu decongestants, the second largest OTC category (£100m), declined by 3.7 per cent, but also by 11.3 per cent in the first four weeks of the New Year compared to a year ago.

Cough liquids, a category worth more than £65m, witnessed a larger annual decline, down 8.9 per cent, and a drop of 6.8 per cent in the first four weeks of the New Year.

Similarly, medicated confectionery (£42m), declined by 4.8 per cent and 12.2 per cent respectively. However, indications of a late seasonal peak in cold weather and flu occurrence could lead to a recovery of these markets.

UniChem

Pharmacy Fantasy League update - Italy show guts, but just can't beat France

On March 3rd, the Italian rugby team, sponsored by Alliance UniChem battled hard against France at their home ground in Rome.

After a strong start - good scrummage and functional line-outs - Lo Cicero made some prominent advances and Persico contributed well. But it was Perziano who scored a try and star player, Dominguez, who secured a conversion and four penalties to bring the score to 19 for Italy. France meanwhile managed to notch up a total of 30.

This was the second of the three games that count in our Pharmacy Fantasy League. The leading contestant so far is: D Bowen of Macclesfield, closely followed by D.Smith of Sheffield, R. Simmonds of Oundle, near Peterborough, R. Heaps of Scarborough, A. John of Verwood, Dorset, B. Roe or South Shields and P. Crutchley of Corsham, Wilts.

The last game in our competition takes place this weekend, when Italy take on the Scots at Murrayfield so don't forget to watch.

We'll be announcing the winner in our next update on 6 April – they will be jetting off to see Italy's final game against Wales, while the 25 runners up will be able to cheer them on in their Alliance UniChem branded rugby shirts.

A WOMAN GOES INTO A PHARMACY AND SAYS, "WHAT HAVE YOU GOT FOR AN ITCHY, FLAKY SCALP?"

The pharmacist says, "Oilatum Scalp Treatment Shampoo will sort it out nicely. It's the only one with ciclopirox olamine – that'll kill the yeast that's causing all the trouble."

And she says, "thank you very much, I'll take some." We know this story isn't very funny. But then neither is an itchy, flaky scalp.

THE END.

For free samples call 0800 7836699
www.oilatum.co.uk

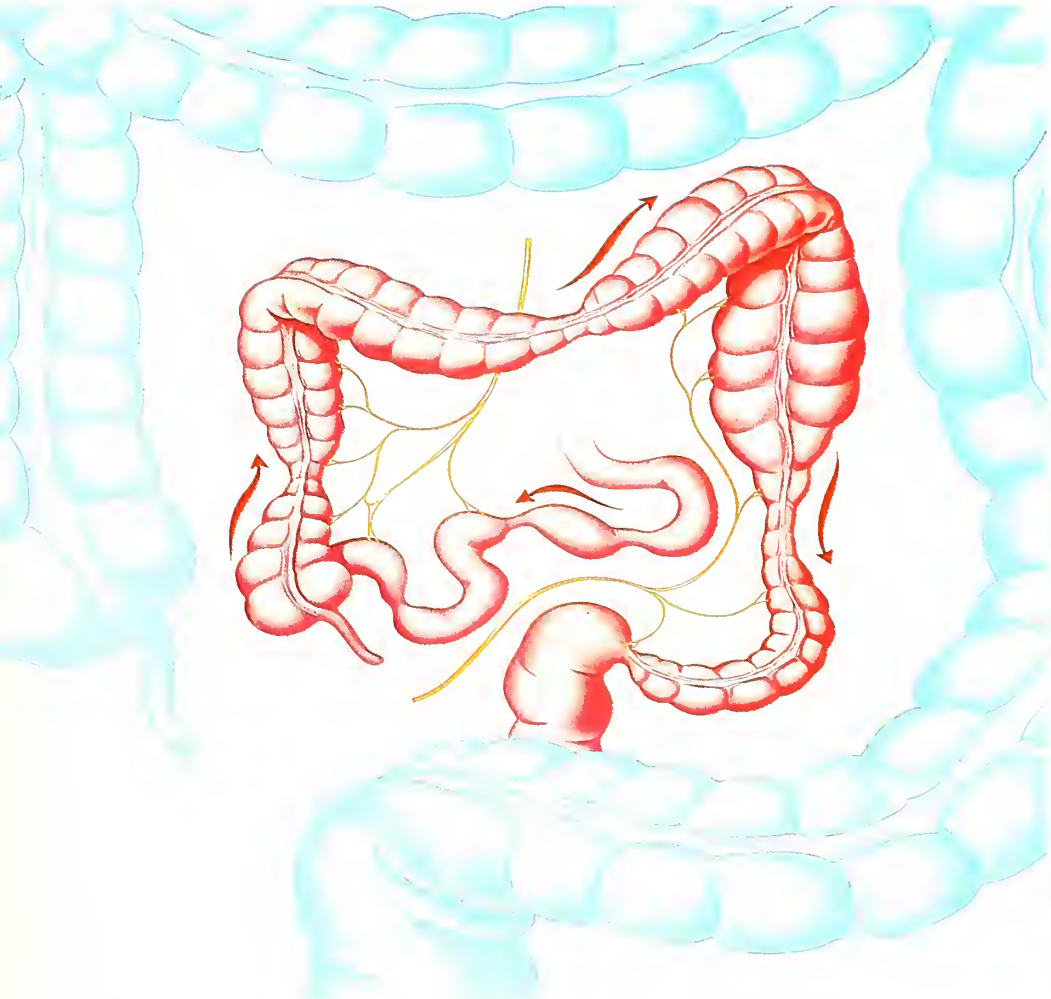
PHARMACYupdate

A source of irritation

Irritable bowel syndrome
IBS may be widespread, but its cause is still not known I

Drugs & the elderly
Depression in the over-65s can often be attributed to side effects of medication VI

Case history
A patient presents with an unusual mixture of symptoms. Is it side effects or illness? X



John Bavosi/Science Photo Library

THE COLLEGE OF PHARMACY PRACTICE

THIS COURSE (MODULE 1194), IN ASSOCIATION WITH MULTIPLE CHOICE QUESTIONS BEING PUBLISHED IN *C&D* APRIL 14, PROVIDES ONE HOUR'S CONTINUING EDUCATION

OBJECTIVES

- To be aware of the incidence of IBS and its effect on quality of life
- To distinguish the different ways in which the symptoms of IBS can can present
- To understand the likely causes of IBS
- To be aware of treatment options for IBS

Irritable bowel syndrome is a widespread, yet misunderstood, condition. Steve Bremer looks at the symptoms, possible causes and treatment

Irritable bowel syndrome is the second most common couse of work and school absenteeism after the common cold. More than half of sufferers experience symptoms daily that affect their social and working lives. But, although IBS is so widespread, its cause is still not known and there is no cure.

IBS is known as a functional disorder, because there is no sign of diseose when the bowel is examined. It causes a great deal of discomfort and stress, but does not cause permanent damage to the intestines or lead to more serious pathology such as bleeding of the bowel, or cancer.

Often IBS is just a mild annoyance, but for some people it can be disabling. They may be afraid to go to social events, to go to work or travel even short distances. Most patients, however, are able to control their symptoms through combinations of diet, stress management and medication.

The causes of IBS are so widespread thot it is almost impossible to lay down a textbook diagnosis. However, it is known that diet, stress and other psychological factors cause symptoms, which include low abdominal poin, flatulence, tenesmus (a feeling of incomplete emptying of the bowel), constipotion ond diarrhoea.

IBS is three times more common among women than men. Many people endure symptoms for years, then these disappeor as suddenly as they arrived. As sufferers get older, symptom intensity may reduce or become less of a problem.

There are three generally accepted variants of IBS:

- spastic colon
- functional diarrhoea
- foregut motility disorder.

Each has its own range of symptoms but since some of these overlop, diagnosis is not always straightforward.

1 Spastic colon

Lower abdominal pain, often acute and piercing, is o common symptom. The pain may pass quickly, but con last for hours or even days. Relief comes with defecation. Frequently, the onset of pain is associated with the passage of looser stools than

Continued on PII →

Continued from P1

normal, abdominal distension or swelling, and an unsatisfactory bowel habit.

There may be mucous in the stools, and a frequency of bowel action. At other times, sufferers are constipated. Spastic colon is a debilitating and often chronic condition.

2 Functional diarrhoea

Sufferers report an urgency of bowel movements, with several stools in rapid succession, usually first thing in the morning (known as 'the morning rush'). This is probably the most difficult form of IBS to manage. Patients can become housebound because the urgency is uncontrollable.

Most cases are less severe, but patients will still plan journeys around availability of toilet facilities. Some are unable to travel on public transport or by car.

3 Foregut motility disorder

This variant is quite common and is particularly distressing for women. It causes severe bloating and abdominal pain – often right-sided. Waistlines may expand several inches, and sufferers need to wear loose clothing to accommodate the bloating.

Sufferers often feel very full after meals. Alternatively, they feel very hungry, but become full and bloated after eating small amounts of food. This often leads to a loss of appetite. Foregut motility disorder is distinguished from the two other IBS variants by a lack of disturbance of bowel action.

Causes of IBS

Abnormalities of intestinal motility

In spastic colon, exaggerated and abnormal motility of the colon may give rise to symptoms of crampy lower abdominal pain and may be the cause of a disordered bowel habit. In the foregut motility variant, pain occurs in association with exaggerated and disordered small intestinal motility, and in association with hypomotile activity.

The hypersensitive gut

In IBS patients the gut is hypersensitive. Nerve endings lining the intestine become more sensitive than normal, in effect up-regulating. One reason patients suffer so much pain may be that excessive numbers of messages are sent from the gut to the brain. Trigger factors for this hypersensitivity are unknown.

Table 1: Manning Criteria

- abdominal pain relieved by opening the bowels
- onset of abdominal pain associated with the passage of looser than normal stools
- abdominal distension
- a feeling of incomplete evacuation
- the passage of mucous via the rectum
- the onset of abdominal pain associated with a more frequent passage of stools

Diet

The role of diet in IBS is contentious, with studies of the issue producing conflicting results. Generally speaking, spicy foods, fried and fatty foods, green vegetables, citrus fruit, cheese and onions should be avoided by most patients. To confuse the issue, green vegetables also appear on a sufferers' list of helpful foods. In summary, experiences vary between individuals and they must decide for themselves.

Sexual and physical abuse

Several studies have linked abuse in women to the development of IBS. Abuse includes physical, sexual, emotional or verbal forms. This may be due to the fact that psychological factors influence the chemical activity of the CNS, which in turn influences the muscular activity of the intestine.

It has been suggested that enquiries into past histories of sexual abuse may provide help for sufferers whose symptoms are not controlled by standard treatment. In people who have suffered abuse, predominantly females, they have at least a twofold chance of developing irritable bowel.

Other factors

Stress, as well as anxiety or depression can cause or exacerbate symptoms. Occasionally, psychiatric disorders can actually cause IBS symptoms, thus making these the primary diagnosis. Consequently, these patients should be treated with psychotropic drugs.

Severe gut infections predispose to IBS, particularly in women. Major bacterial causes are *Campylobacter jejuni* and species of *Salmonella* and *Shigella*.

Many patients claim their symptoms started after taking antibiotics. However, there is not much evidence to support this theory.

Diagnosis

Because of the wide variety of symptoms reported by different patients, the Manning Criteria were developed in 1978 to enable a positive diagnosis on the basis of a number of clinical features (see Table 1).

When it became evident that functional diarrhoea was a distinctive variant of IBS, the 'Rome Criteria' were developed to take this into account (Table 2).

Some experts believe that both the Manning and Rome Criteria are too restrictive and do not take into account the wide variety of symptoms seen in IBS.

Treatment

Treating pain

Since IBS is characterised by alterations to gut motility, the use of antispasmodic and other drugs that affect gut motility is one treatment option.

Antimuscarinics reduce intestinal motility. Those used for GI smooth muscle spasm include the tertiary amines atropine sulphate and dicycloverine hydrochloride, and the quaternary ammonium compounds propantheline bromide and hyoscine butylbromide.

Antimuscarinics should be used with caution in Down's syndrome, children and the elderly because of the increased risk of side effects. They are contraindicated in angle-closure glaucoma, myasthenia gravis, paralytic ileus, pyloric stenosis and prostatic enlargement. Preparations available OTC include Kalonticon gel and Buscopan tablets.

Alverine, mebeverine and peppermint oil are believed to be direct relaxants of the intestinal smooth muscle. They have no serious adverse effects but, like all antispasmodics, should be avoided in paralytic ileus. Peppermint oil occasionally causes heartburn. OTC preparations include Colofac IBS, Colpermin, Equilon and Equilon Herbal, Fybogel Mebeverine, Mintec and Relaxyl.

Table 2: Rome Criteria

At least three months of continuous or recurrent symptoms of:

- **abdominal pain, relieved with defecation, and/or associated with altered frequency or consistency of stool**

And/or:

- **disturbed defecation – two or more of:**

– altered stool frequency (more than three movements per day, or fewer than three a week)
– altered stool form (hard or loose/watery)
– altered stool passage (straining or urgency, feeling of incomplete evacuation)
– passage of mucous

usually with:

- **bloating or a feeling of abdominal distension**

Treating constipation

Constipation occurs either because transit through the colon is slow or because there are problems evacuating the bowel. Some patients may perceive they are constipated because they have difficulty evacuating small, pellety stools from the rectum.

In slow transit constipation, patients should increase the fibre content of their diet. This is best achieved through a well-balanced fibre diet. The fibre should be obtained from different sources and these should be rotated, as the bacteria in the gut that break down fibre recognise a constant source. They then break it down more efficiently, consequently reducing its effectiveness in bulking the stool.

Constipated patients should also be advised to increase their fluid intake to a minimum of two litres daily. Fibre supplements such as Fybogel and Regulan are effective in some patients but they should be taken in addition to a high fibre diet, not instead. Their use should be restricted to an intermittent basis as their effectiveness also wears off over time.

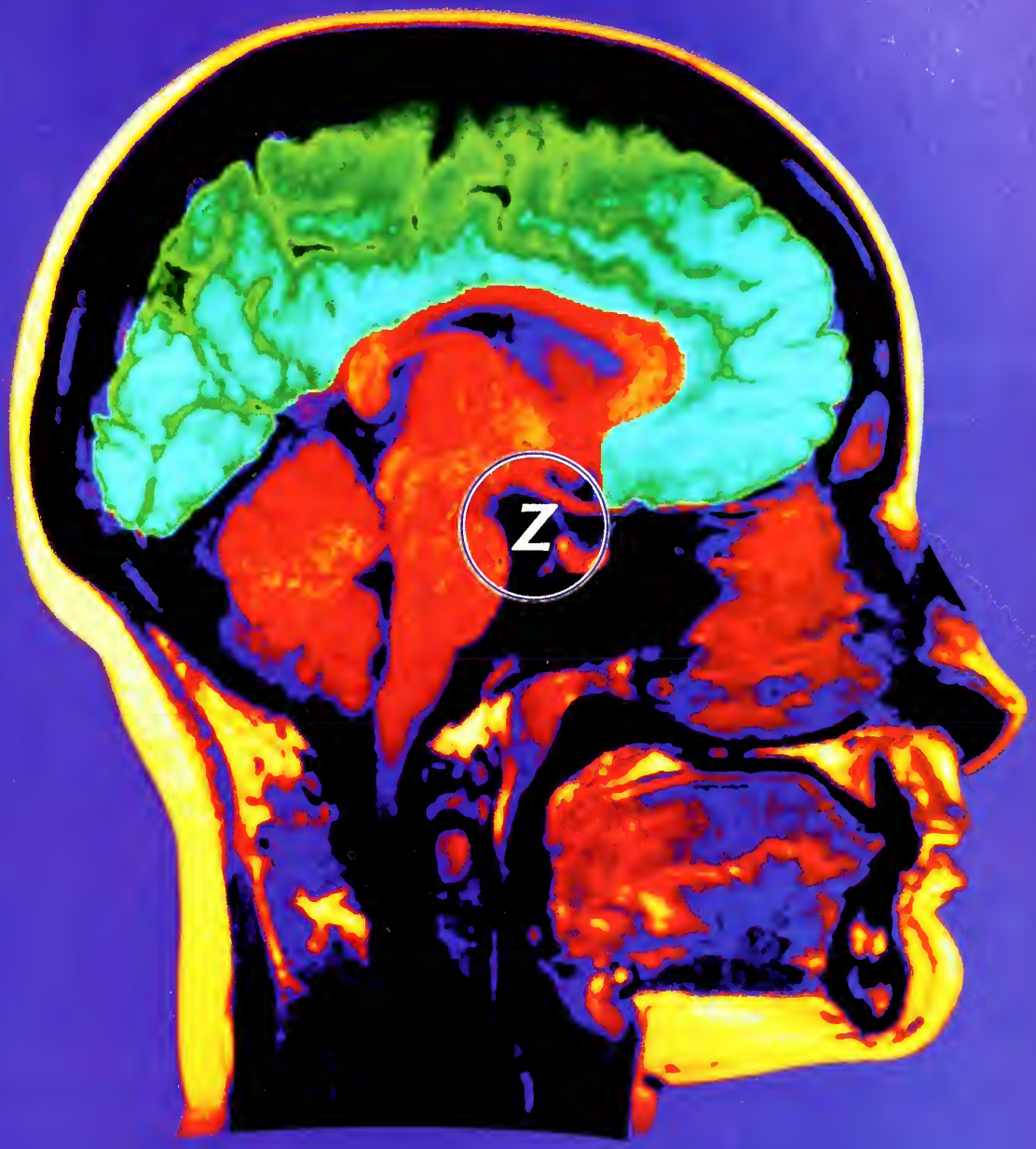
Laxatives may be necessary in addition to dietary manipulation in some cases, at least in the early stages of treatment. Irritant laxatives are not the first choice, as they stimulate intestinal motility in a way that may counteract other efforts to normalise motility with smooth muscle relaxants or antispasmodics.

Osmotic laxatives are the preferred option. The volume of fluid entering the colon from the small intestine is increased, which stimulates motility of the right side of the colon. Because they increase colonic volumes, osmotic laxatives also lead to a softening of the stool.

Unfortunately, lactulose and lactitol contain a form of fibre and are broken down in the colon. This produces gas, which can result in further bloating and pain and passing of gas. As with the irritant laxatives, the osmotic laxatives are broken down more efficiently when taken over a period of time.

Continued on PIV →

FOR SMOKING CESSATION
Z MARKS THE SPOT



Nicotine addiction is a neurobiologically-mediated brain disease.[1] Zyban is a unique non-nicotine tablet therapy that works in the brain by acting on the neurotransmitters involved in nicotine addiction and withdrawal.[2,3]

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s Smoking cessation (with motivational port) in nicotine-dependent patients. **age and administration** *Adults from years:* Start treatment while still king and set 'target stop date' within two weeks. 150 mg o.d. for 3 days then mg b.d. for remainder of 7 to 9 week se. Maximum 150 mg single dose and mg daily. Allow at least 8 hours veen doses. Discontinue if no effect at k 7. *Elderly, renal or mild-to-moderate atic impairment:* 150 mg o.d. **Contra-cations** Hyper-sensitivity, ious/current seizure or eating rder, recent/current MAOIs, severe atic cirrhosis, bipolar disorder. **cautions** Predisposition to lowered ure threshold/increased risk of ures (including previous head injury, n tumour, other medications, alcohol se, diabetes), renal or mild-to-derate hepatic impairment, elderly, eptibility to psychotic episodes. **Drug ractions** Theophylline, tricyclics, SSRIs, OIs, antipyschotics, beta-blockers, s 1c antiarrhythmics, enzyme inducers/ ltors, orphenadrine, cyclophosphamide, dopa. **Pregnancy and lactation** Not mmended. **Side effects** *Common:* mouth, gastrointestinal pain/upset, mnia, tremor, concentration disturbance, dache, dizziness, depression, agitation, ety, rash, pruritus, urticaria, sweating, r, taste disorders. *Uncommon.* chest , asthenia, tachycardia, blood pressure nges, flushing, confusion, anorexia, tus, visual disturbance. *Rare:* vasodilation, ope, seizures, severe hypersensitivity tions including anaphylaxis, arthralgia, lgia and fever, erythema multiforme, ens Johnson syndrome. **Presentation Basic NHS cost** 60 tablets £42.85 **duct Licence (PL) no.** PL10949/0340. **holder** Glaxo Wellcome UK Ltd., kley Park West, Uxbridge, UB11 1BT. M

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GlaxoSmithKline

26670/D - February 2001

Continued from PII

Treatment of diarrhoea

Frequency of bowel action with urgency most commonly occurs in the functional diorrhoea variant. Loperamide is the most common treatment, although opinions differ as to the preferred dosage regime. One option is a regular dose first thing in the morning and an additional midday dose if necessary.

Small doses of tricyclic antidepressants taken at night may reduce bowl frequency. This could be due to the fact that they increase the transit time for intestinal contents.

Prokinetic agents

In patients with foregut motility disorder, movement of contents through the small intestine may be slow. Prokinetic agents such as cisapride may be beneficiol in this IBS variant.

In some patients prokinetic ogents can stimulate colonic contractility and reduce transit time through the colon. They can benefit some patients with the spastic colon syndrome, whose main problem is one of slow transit constipation.

New developments

Last Februory, Lotronex (alosetron) was opproved by the US Food & Drug Administration for the management of abdominal pain associated with IBS.

Glaxo Wellcome voluntarily withdrew the drug in November following reports of links with ischaemic colitis and complications from constipation. The US was Lotronex's only market.

Novartis has applications filed for tegaserod (Zelmac) worldwide. Tegaserod selectively blocks 5-HT4 receptors in the gastrointestinal tract. These receptors appear to play a role in GI motility and moy be involved in pain perception. By acting on the 5-HT4 receptor pathway, tegaserod relieves abdominal pain and constipation.

The evidence reviewed

A review of 28 high-quality trials in IBS found that only three interventions had a high proportion of positive trials (*Bandolier*, September 2000;79;5):

David Gifford/Science Photo Library

- smooth muscle relaxants were consistently effective in reducing abdominal pain associated with IBS, with numbers needed to treat for individual trials in the range of two to six
- loperamide was effective in treating diarrhoea associated with IBS
- 5-HT receptor antagonists appeared to be effective both in terms of global improvement and some individual symptoms, although they can cause constipation.

Management

Diet

As mentioned earlier, the role of diet in IBS is debatable, but there are guidelines worth following:

- if patients have identified foods or drinks that improve their symptoms, they should be encouraged to continue with them
- conversely, if foods are identified as trigger factors, avoid them
- core needs to be taken before advising a high-fibre diet
- caution is required before recommending dairy-free, gluten-free and yeast-free diets. There is little evidence to support their benefits
- alcohol and caffeine intake should be reduced. Both substances stimulate movement into rather than out of the gut. This increases the amount of fluid within the gut, and worsens symptoms
- aloe vera is widely used by IBS patients, but has been shown to be of benefit in less than a quarter of cases.

Psychological

IBS sufferers are more concerned about illness in general than controls. They suffer more severe disease phobias, are more hypochondriacal and more preoccupied with bodily functions.

It follows therefore, that psychological treatment can be an effective form of management in IBS. Treatment ranges from psychotherapy to more detailed cognitive behavioural therapy and hypnosis.

Mood disturbances occur commonly in IBS patients. Despite the fact that it is not clear whether mood disorders are part of IBS or occur alongside the condition, antidepressants can sometimes bring about dramatic results.

C&D is accredited by the College of Pharmacy Practice as provider of distance learning until June 2001

RESOURCES

'Understanding your irritable bowel' by Dr D Silk, director of the IBS Research Programme. Available by sending a cheque for £12.00 made payable to IBS Research to Freepost Lon 10960, London SW20 8BR

ACTION PLAN

1. How would you diagnose IBS? Can you and should you?
2. If you cannot diagnose the condition, how would you treat a patient with symptoms that may be IBS?
3. Using the *BNF*, list in your practice workbook the preparations you would advise for a patient who may have an attack of IBS (if they have been diagnosed by a doctor)
4. Do you agree that more women than men suffer from IBS? Do IBS patients appear to be 'more concerned about illness' than other patients. Can you think of other conditions with a similar psychological profile?

PHARMACYupdate: distance learning for pharmacists

Pharmacists using Pharmacy Update for continuing education are reminded of the need to test. With the support of Genus Pharmaceuticals, *C&D*'s readers can self-test their progress by using the multiple choice question (MCQ) paper to be inserted in the April 14 issue, which will cover this week's CPP-accredited modules, together with those in the March 3 issue.

In other words:

- Managing asthma (1193)
- Irritable bowel syndrome (1194)
- Drugs in the elderly (1195).

A faxback service for these modules and associated MCQs operates on 0891 444791 (premium rates apply). A telephone marking service offers independent verification of results – details are given on the monthly MCQ papers.

C&D in association with

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BBREVIATED PRESCRIBING INFORMATION
eoclarityn (desloratedine) 5mg film-coated tablets. **sas:** Neoclarityn is indicated in adults and dolescents for the relief of symptoms associated ith seasonal allergic rhinitis. **Dosaga:** *Adults and hildren 12 years and over:* One 5mg tablet, once aily. **Contra-indications, Precautions:** Hyper-ensitivity to desloratadine, loratadine or excipients. fficacy and safety of Neoclarityn have not been stablished in children under 12 years of age. eoclarityn should be used with caution in patients ith severe renal insufficiency. Neoclarityn does not otentiate the performance-impairing effects of cohol. No clinically relevant interactions ware bserved in clinical trials in which erythromycin or etoconazole were co-administered; however, some teraction with other drugs cannot be fully excluded. he safe use of Neoclarityn during pregnancy has ot been established. Neoclarityn should not be sed during pregnancy unless the potential benefits utweigh the risks. Desloratadine is excreted into east milk, therefore the use of Neoclarityn is not ecommended in breast-feeding women. Neoclerityn as no or negligible influence on the ability to drive nd use machines. **Side-effects:** At the recommended ose of 5mg daily, undesirable effects with eoclarityn in excess of those treated with placebo ara reported in 4% of patients. The frequency of dverse events in excess of placebo is: > 1/100, 1/10 headache; > 1/1,000, ≤ 1/100 dry mouth; 1/1,000, ≤ 1/100 fatigue. Overdose: In the event of verdose, consider standard measures to remove nabsorbed active substence. Symptomatic and upportive treatment is recommended. No clinically levant effects were observed following dministration of up to 45 mg of desloratadine times the clinical dose). Desloratadine is not iminated by haemodialysis; it is not known if it is iminated by peritoneal dialysis. **Presentation:** eoclarityn is supplied in unit dose blisters omprised of laminant blister film with foil lidding. acks of 30 tablets. **Basic NHS Price:** £7.57. **arketing Authorisetion Number:** EU/1/00/161/011, tablets. **Legal Category:** Prescription only.
ate of Preparation: November 2000.

ARITYN TABLETS AND SYRUP
BBREVIATED PRESCRIBING INFORMATION
arityn (loratadine) Tablets and Syrup. **Uses:** arityn is a long acting antihistamine with selective ripheral H_1-receptor antagonist action and no ntral sedative or anticholinergic effects. It is dicated in adults for the relief of symptoms sociated with seasonal and perennial allergic nitis, such as sneezing, nasal discharge and hing and ocular itching and burning. It is also licated for the relief of idiopathic chronic urticaria. rityn Syrup is indicated in children for the mptomatic treatment of seasonal allergic rhinitis d allergic skin conditions. **Dosage:** *Adults and ildren 12 years and over:* 10mg once daily. *ildren 6-12 years:* 2 x 5ml spoons of Clarityn Syrup mg) once daily. *Children 2-5 years:* 1 x 5ml oon of Clarityn Syrup (5mg) once daily. **Contre-lications, Precautions:** Hypersensitivity. Pregnancy d lactation. Discontinue four days prior to skin ting. **Side-effects:** Rarely, fatigue, nausea and adache, alopecia, anaphylaxis, abnormal hepatic ction, supraventricular tachyarrhythmias. chycardia and syncope have also been reported ely although causal relationship has not been ablished. Concomitant administration of drugs ch inhibit P450 3A4 and 2D6 metabolic pathways y result in elevated plasma levels of loratadine or concomitant medication. See Data eet for further information. **sentation:** Clarityn Tablets - te oval tablets, plain on one e, with a deep score, flask dish logo with number 10 on other, containing 10mg tadine. Cartons of 30 tablets, each taining three blister strips of tablets. Clarityn Syrup - clear, urless to light yellow syrup with each flavour, containing 5mg tadine per 5ml, in bottles of ml. **Basic NHS Price:** Tablets 7; Syrup £7.57. **Product Licence mbers:** Clarityn Tablets 0201/0175; ityn Syrup 0201/0173. **Legal egory:** Clarityn Tablets - POM; ityn Syrup - P. Further information ilable from the **Product Licence der:** Schering-Plough Ltd, Shire Park, wyn Garden City, Herts., AL7 1TW. **of Revision:** August 1997.
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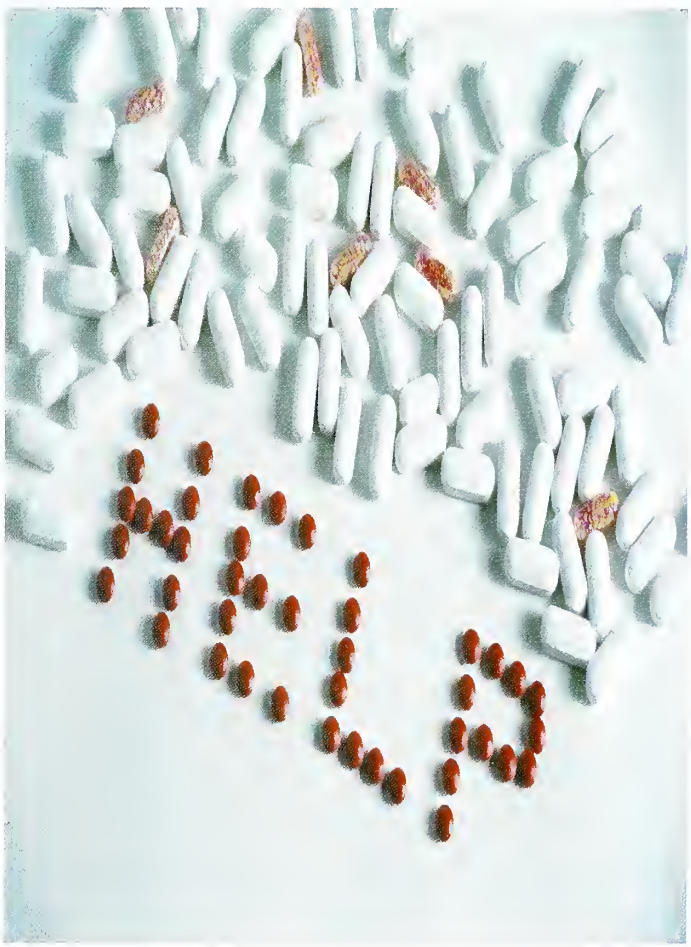
Don't let the drugs get you down

Many drugs cause depression in the elderly. Professor Malcolm Lader explains the current evidence



Depression is prevalent among the over-65s, with around a third having symptoms.[1] It should be treated vigorously, but as this group is a large user of medicines, it is first worth considering whether the disorder has occurred as a result of other medication.

Suspect drugs should usually be withdrawn, with alternative agents given, and the patient followed up carefully, to confirm the association. Re-challenge, while the 'gold standard' for further confirmation, is often fraught with risk.

Antihypertensives

The depressive effect of drugs was discovered 40 years ago, when reserpine was identified as being 'depressogenic' due to its depletion of serotonin.[2] In fact, this observation largely gave rise to the biogenic amine hypothesis of mood disorders. Since then many other antihypertensives have been found to have similar effects. Methyldopa, which depletes both serotonin and dopamine, is said to cause depressive symptoms in up to 10 per cent of patients. Avoidance of this drug is advised in patients with a history of depression.[3]

Another group of antihypertensives linked with depression is the ß-blockers. Several reports present a convincing case that these agents cause true depression, although consideration should be given to their ability to cause fatigue and lethargy. Mood changes with ß-blockers occur whether or not the drug crosses the blood-brain barrier.[3]

In a study of co-prescription of antidepressants and ß-blockers, propranolol had the highest rate of co-prescribing, followed by other lipophilic then hydrophilic drugs.[4] Ophthalmic ß-blockers may also be systemically absorbed, with similar adverse events reported in glaucoma treatment.[5]

Calcium channel blockers have been linked to both depression and suicide, although causality has not been confirmed. Calcium is believed to have a role in the pathophysiology of depression and mania via its effect on dopamine release.[3,5] Only case reports, rather than clinical trials of depression with nifedipine, verapamil and diltiazem, comprise the evidence for these agents.[5] Also in the literature is a report of depression cases, which have been induced by thiazide diuretics prescribed for hypertension.[6]

Antihistamines

Cinnarizine also has calcium channel blocking activity, and several reports have described depression associated with its use.[5]

CNS drugs

Antiparkinsonian agents

Abnormalities in the disposition of the neurotransmitter dopamine, as well as noradrenaline and serotonin, are associated with depression. Thus we can expect this side effect to occur in the dopaminergic treatment of Parkinson's disease, namely with levodopa. However, depression occurs as part of the Parkinson syndrome itself and it is difficult to distinguish this side effect of treatment from the disease itself.

Although results are conflicting, one trial found that the vast majority of those patients who developed a depressive disorder were on levodopa or levodopa with carbidopa.[2] The incidence of depression with levodopa is reported at about 9 per cent, with these patients often requiring antidepressants.[7]

Neuroleptics

As in Parkinson's disease, the problem of depression in psychotic disease is complex and it can be difficult to distinguish an effect due to treatment. Neuroleptics have been accused of causing a depression-like syndrome, which should be differentiated from akinesia. Long-acting drugs have been particularly implicated, but the evidence is conflicting.[2,8] Many believe that the risk of suicide in untreated psychotic patients, such as schizophrenics, is greater than in those receiving neuroleptic agents.

Metoclopramide

A few reports of depressive episodes apparently induced by metoclopramide appear in the literature, many accompanying the adverse effect of extrapyramidal episodes. Metoclopramide does have activity as a dopamine D2 antagonist, although no epidemiological studies have evaluated the link between depression and this agent.[5]

Benzodiazepines

Depression is a common paradoxical effect apparently seen with benzodiazepine therapy, or on withdrawal. However, there are no substantial trials to support this theory.[5] Used as anxiolytics or hypnotics, these agents can produce poor sleep patterns and may also increase irritability.[9] As with previous conditions, adverse effects could be confused with the indications. Thus, when benzodiazepines are used to treat anxiety accompanying depression, the lessening of the anxiety unmasks the depression.

Anticonvulsants

As in other CNS conditions, the association of depression with epilepsy is difficult to separate from drug effects. Various mental symptoms are known to develop during the course of long-standing epilepsy. Phenytoin has been linked with subtle mental changes such as impairment of drive and initiative, psychomotor slowing and depression of mood. These occur even at drug concentrations within the therapeutic range.[2] Case

Continued on PVIII →

THE COLLEGE OF PHARMACY PRACTICE

THIS COURSE (MODULE 1195), IN ASSOCIATION WITH MULTIPLE CHOICE QUESTIONS BEING PUBLISHED IN *C&D* APRIL 14, PROVIDES ONE HOUR'S CONTINUING EDUCATION

OBJECTIVES

- To be aware of the incidence of depression in the elderly
- To recognise the potential link between depression and medication in the elderly
- To be aware of which classes of drugs may exacerbate depression in the elderly
- To know which commonly used drugs list depression as a side effect

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L001107(b)

Continued from PVI

reports suggest that carbamazepine may also cause depression.[3]

Anti-ulcer drugs

Depression has been reported with some of the H_2 antagonists, a common prescription for elderly patients. However, epidemiological evidence for an association is lacking.[5]

Cimetidine crosses the blood-brain barrier and has been reported to have CNS effects. Depression is one of these effects, but is thought to occur rarely.[10] Depression has been estimated to occur in 1-5 per cent of patients taking ranitidine.[7] A rapid improvement in three patients with severe depressive symptoms, on cessation of ranitidine therapy, has been reported.[11]

Drugs used in arthritis

Depression has been documented with the non-steroidal anti-inflammatory agent indomethacin[12] and with the newer COX-2 selective inhibitors, celecoxib and rofecoxib.[13,14] The summary of product characteristics for celecoxib lists depression as an undesirable effect, with an incidence of 0.1-1 per cent.[13] Anxiety and the more common adverse effect of insomnia can also mimic depressive symptoms with celecoxib use.

Recent data on rofecoxib from the Committee on Safety of Medicines shows that depression has been reported as a psychiatric reaction in 28 cases, as well as confusion (14 reports) and hallucinations (11 reports).[14] Most patients were reported to have recovered after drug withdrawal. For the remainder, the outcome was not known at the time of the report.[14]

Interestingly, the COX-2 selective agent meloxicam has demonstrated mood-elevating effects in a comparison with diclofenac.[15] A trial of 244 patients with osteoarthritis of the hip reported significant increases in emotional stability and decreases in emotional distress compared with diclofenac after three months' treatment. The quality of life measures, which increased with meloxicam use relative to baseline, included "positive feelings despite disease", "generally feeling fine", feeling "optimistic", and that "the future is worth living". Compared with diclofenac, meloxicam increased patients' satisfaction with themselves and their feelings of optimism.

Corticosteroids

Endogenous glucocorticoids have pharmacological effects on the CNS, so it is logical to expect mental and neurological disturbances to arise from the use of these agents as medicines. It has been known for some 40 years that depression is linked with Cushing's syndrome.

Indeed, there is considerable literature reporting that the use of systemic corticosteroids can result in similar effects, especially when used in high doses.[5,16] Both mania and depression can result.

Antineoplastic agents

Interferon-α (used in hepatitis treatment as well as in cancer therapy) is associated with a high risk of central adverse effects. Depression is cited as a major reason for discontinuation of treatment, with incidence rates of 14-39 per cent reported. Suicidal ideation and attempt are also documented.[17]

The rates published for adverse events with tamoxifen vary widely. However, mild depression is one of the effects documented.[18]

Depression has been reported with gonadotrophin hormone releasing hormone in premenopausal women.[19] However, in older patients, this agent is more likely to be used in men for prostate cancer treatment, with this effect not an apparent problem.

Digoxin

Digoxin toxicity may sometimes be mistaken for depression. However, one population-based survey of elderly patients on the drug found elevated mean depression scores. In addition, a prospective study of postmyocardial infarction patients showed that exposure to digoxin was a statistically significant predictor of depressive disorders at three to four months post event.[5]

A summary of the agents mentioned in this article, and whether or not depression is a side effect noted for them in the *BNF*[20] is given in Table 1.

A list of other drugs that have been associated with depression is given in Table 2.

Table 1: Summary list of Depression specifically noted in BNF as side effect[20]

Anticonvulsants	Ethosuximide, phenobarbital, vigabatrin, tiagabine, topiramate
Antihistamines	Depression noted as class effect
Antineoplastic agents	Gonadorelin analogues ('mood changes' noted as class effect), aminoglutethimide, toremifene, interferon-α (class effect)
Benzodiazepines	–
ß-blockers	Carvedilol, celiprolol, nebivolol
Calcium channel blockers	Amlodipine ('mood changes'), diltiazem, lacidipine ('mood disturbances'), nicardipine, nifedipine
Corticosteroids	Depression noted as class effect
Digoxin	–
H2 antagonists	Depression noted as class effect
Levodopa	Yes
Methyldopa	Yes
Metoclopramide	Yes
Neuroleptics	chlorpromazine and related drugs, zotepine
NSAIDS	Indomethacin (Celecoxib not yet in current *BNF*, but depression mentioned in SPC)

Table 2: Other drugs that may be linked with depression

	Depression specifically noted in *BNF* as side effect[20]
Amphetamines (withdrawal)	–
Anabolic steroids	Stanozolol
Appetite suppressants (withdrawal)	Phentermine
Chloroquine	–
Disulfiram	Yes
Isotretinoin	Yes, severe depression
Mefloquine	Yes
Quinolone antibiotics	Depression noted as class effect
Statins	–
Sulphonamides	Co-trimoxazole and related drugs
Theophylline	–

Conclusion

Depression as side effect of drug treatment may be confounded with disease in many circumstances and there are few epidemiological studies to link depression with a particular agent, most descriptions being case reports.

It should be borne in mind that many physically ill patients became depressed. Also, there is a higher incidence of depression as a side effect of administered drugs in those who have been treated previously for the condition. This may be because those who have experienced depressian interpret certain autanomic effects such as lethargy and retardation as 'depression', as opposed to a physical side effect. On the other hand, it may be that these patients are physiologically more vulnerable to drug effects.

There are few guidelines in the literature on the treatment of drug-induced depressian, particularly if there are na alternative agents for the patient cancerned. However, awareness of the problem may help clinicians recognise and resolve symptams at an early stage.

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This article first appeared in *Geriatric Medicine*, December 2000

References available an request

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ACTION PLAN

1. What is meant by the term 'depression'? Write a short definition in your practice workbook.
2. Having considered the term, now write a list of symptoms in your workbook.
3. Think about mental illness. Look at the *BNF* sections 4.2, 4.3 and 4.11. Can you distinguish between the terms used by healthcare professionals to define such illness?
4. How does the public react to terms such as schizophrenia? What can you do to help reduce their apprehension about these patients?
5. Take note of your next 20 patients who you feel are depressed. Record their prescriptions and examine their PMRs. Using the list of drugs in the article, can you find any suggestion that their drug regimen may be the causing their depression? If so, what will be your next step?

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Side effects or symptoms?

A patient presents her pharmacist with an unusual mixture of symptoms. Mary Allen, FRPharmS, explores whether these are side effects of her medication or symptoms of an underlying condition

Irene Hopkins, a 71-year-old widaw, is a regular customer at Jill Brown's pharmacy. Last November she presented a prescription for Naseptin nasal cream because she had suffered a series of nosebleeds. An earlier blood test had shown nothing sinister – Mrs Hopkins was relieved as she knew that nosebleeds could sometimes indicate conditions such as blood cancers.

Despite her relief, she felt shaky, as the bleeds were very frightening – she lived on her awn and was concerned that she might choke in her sleep. She told Jill that her blood pressure had been raised and her GP was due to check it again next week.

Jill thought that Mrs Hopkins didn't seem herself at all – she was usually calm and collected, but today she was anxious. She had also last some weight. Karen, ane af Jill's dispensers, lived near Mrs Hapkins and knew that she that she had been widawed about six years aga, and that her son had recently been seriausly ill.

Current medication

Atenolol	50mg od
Amlodipine	5mg od
Atorvastatin	10mg on
Aspirin dispersible	75mg om

About three years ago Mrs Hopkins had been prescribed Hirudoid and ibuprofen during a painful attack of phlebitis, and had prescriptions every few months far elastic hasiery.

The following week, Mrs Hopkins returned with a new prescription. She still seemed anxious and quite self-absorbed. Her blood pressure was still high, so the duty doctor had increased her amlodipine ta 10mg daily.

He had also told her that she might benefit from a caurse of antidepressants. Mrs Hopkins seemed annoyed about this and said that she wasn't depressed. She had been told to see her usual GP the following week to discuss this and to check her blood pressure again.

Two weeks later, about ten days before Christmas, Mrs Hopkins visited the pharmacy again with a prescription for sertraline 50mg daily. Jill asked how she was feeling and Mrs Hopkins replied that she had felt a bit light-headed and dizzy. Jill explained that this might be caused by the increased dase af amlodipine. Mrs Hopkins added that she was still feeling very shaky and hadn't been sleeping well, because she was warried about having another nosebleed.

Jill dispensed the prescription and told Mrs Hapkins haw to take her medicine. Jill emphasised the need to take the tablets as prescribed and that she would need ta stay an them for several manths.

Affer Christmas, Mrs Hopkins phoned the pharmacy to ask about side effects af her drugs. She said she was still waking in the night and was still frightened about the possibility of nosebleeds. She also found that now when she woke in the night, she felt hot around her neck and upper chest areas, and felt that her heart was thumping.

Jill asked if she was sweating, but Mrs Hopkins replied that it was a dry burning sensation and was convinced it was due to the antidepressants. When asked how she felt during the day, Mrs Hopkins replied that she didn't have these symptoms in the day, although she felt tired from lack af sleep.

Sometimes Mrs Hopkins felt overcome with weakness, particularly if she had to do something special. For example, she had found herself unable to finish making the Christmas dinner. She had also felt uneasy and shaky in other situations. A lot of the time she felt nauseous, and had lost her appetite. She had also had a few headaches.

Side effects or illness?

Within the last month, Mrs Hapkins had her amlodipine dose increased, and had (12 days later) started taking sertraline. If her problems were caused by a medicine, they were more likely to be due to a side effect or interaction involving one of these changes, since her other medicines had remained constant. **Amlodipine** is a calcium channel blocker. It warks by interfering with the inward displacement of calcium ions through the slow channels af active cell membranes. It relaxes vascular smaoth muscle and dilates coronary and peripheral arteries, and is used for the treatment of angina or hypertension.

Its long duration of action means that it can be given once daily. Side effects associated with vasodilation include flushing and headache (which generally settle down) and sometimes, ankle swelling. A quick look in the *BNF* and summary of product characteristics told Jill that nausea and fatigue could occur, and even palpitations and mood changes – all of which Mrs Hopkins seemed to be suffering to some degree.

The antidepressant **sertraline** is a selective serotonin reuptake inhibitor (SSRI). Looking at the side effects in the *BNF*, Jill saw that it could cause nausea and other gastro-intestinal side effects, as well as anorexia and headache. Sweating could occur, but flushing is not listed. Mrs Hopkins did not appear to be suffering from any of the other listed side effects, and Jill knew that the drug is generally well tolerated.

Jill felt it unlikely that Mrs Hopkins' problems were caused by the sertraline, and did her best to reassure her of this. She also reminded Mrs Hopkins that sertraline, like other antidepressants, takes a while to 'kick in' and she should remain patient. She asked Mrs Hopkins if she had suffered any of her current effects when she first started on amlodipine 5mg.

Continued on PXII →

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Continued from P X

Mrs Hopkins couldn't remember hoving done so, ond certoinly the nocturnol 'burning' sensotion wos new.

Jill decided to investigote some more ond contocted o drug informotion centre ond the drug monufocturer. She olso reod more in her own reference books.

It wos possible thot the omlodipine dose increose might be responsible for the nocturnol 'burning' sensotions, but even this seemed unlikely – the informotion she hod gleoned indicoted thot blood levels of omlodipine would peok in the offernoon (ossuming o morning dose), yet Mrs Hopkins wos olright in the doytime.

Mrs Hopkins' oge mode it unlikely thot the problem wos of menopousol/hormonol origin. Jill olso mode o mentol note to osk the GP obout Mrs Hopkins' ospirin once the other problems hod settled down, os she wondered whether these could hove contributed to the nosebleeds.

Jill doubted thot Mrs Hopkins' medicotion wos responsible for her problems ond urged her to moke on eorly oppointment to see her doctor. She wos concerned thot Mrs Hopkins might be suffering from o physicol illness, or thot her very reol physicol symptoms might be connected to her onxiety.

Medication change

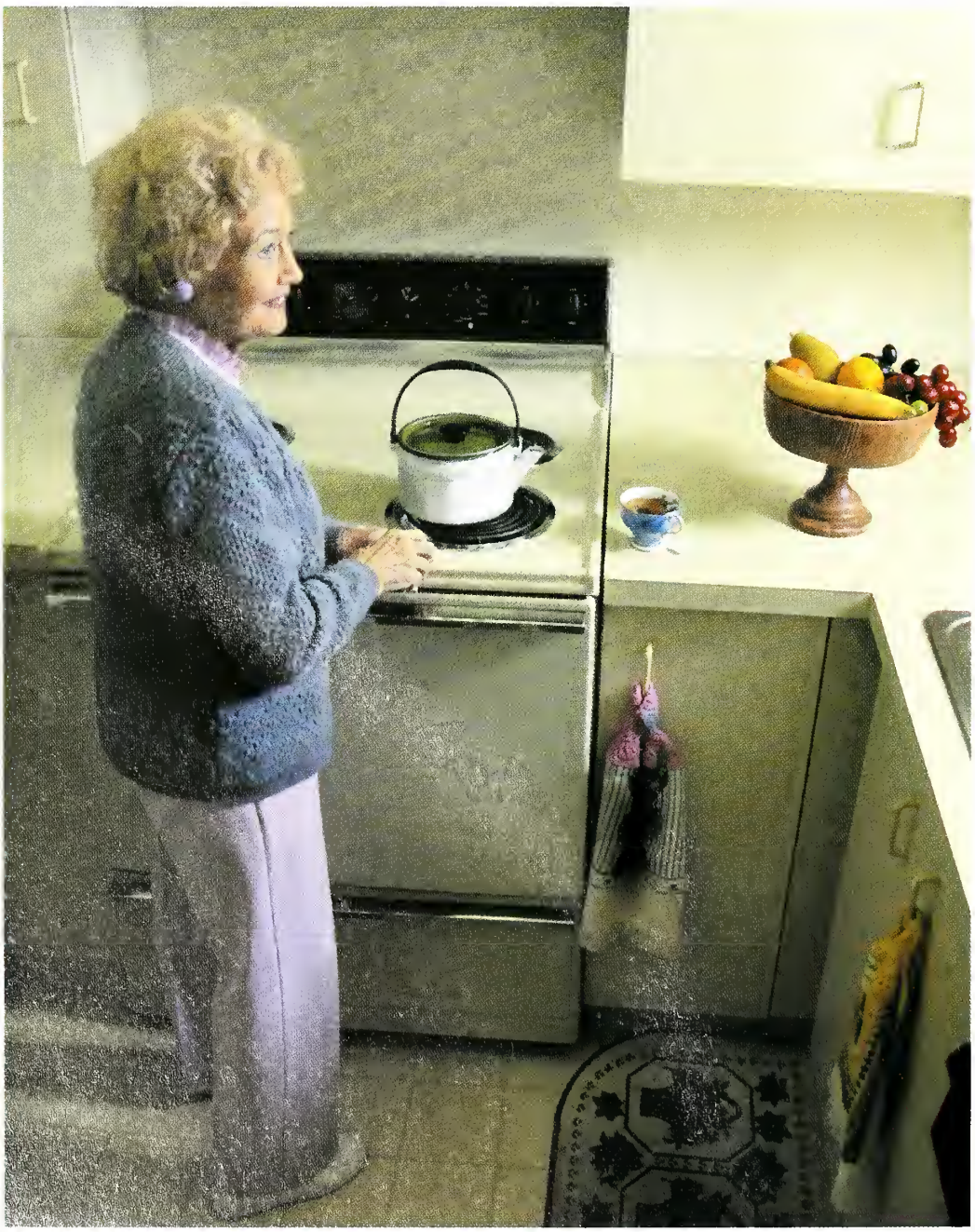
Just ofter New Yeor, Mrs Hopkins popped in the phormocy to tell Jill thot she hodn't yet seen her GP, but hod spoken to the duty doctor on the phone during the New Yeor holidoy period. The doctor hod told Mrs Hopkins to stop toking her sertroline ond to see her GP os soon os the holidoy period wos over.

However, o week ofter discontinuing the sertroline, she wos still woking in the night with the flushing symptoms. She wos to see her GP the following week. Jill felt thot the holf-life of sertroline (24-26 hours) would meon thot there would be little, it ony, of the drug remoining in the body, so Mrs Hopkins' determinotion to blome the ontidepressont wos ill-founded.

Jill decided to hove o chot with Dr Johnson, Mrs Hopkins' GP. He told Jill thot he felt thot Mrs Hopkins wos probobly suffering from clinicol depression with onxiety, ond thot her nocturnol symptoms were olmost undoubtedly due to ponic ottocks. He hod seen Mrs Hopkins lost springtime for o routine cordiovosculor oppointment, when she seemed fine.

Dr Johnson remembered feeling quite shocked ot the chonge in her ot her December oppointment. He knew obout her son's illness ond hod concluded thot the worry of this plus the loneliness of living olone hod probobly contributed to this chonge in her mentol stote.

He wos dismoyed thot the holidoy duty doctor hod odvised discontinuotion of the sertroline over the phone. He would run o series of routine blood tests to check whether there could be ony underlying physicol couse such os thyroid dysfunction, ond then decide whot to do.



Side effects from medication may not necessarily be the main cause of symptoms in a patient

Side effects or panic attacks?

Jill olreody felt pretty sure thot the problems weren't due to the drugs, but wos unowore thot ponic ottocks could couse such profound physicol symptoms os those described by Mrs Hopkins. She decided to leorn more.

Depressive illness moy sometimes be precipitoted by life events such os deoth, divorce or debt. Her son's illness moy hove initioted Mrs Hopkins' grief process ond contributed to her opporent depression. Anxiety is often present with depression, ond Mrs Hopkins wos bound to be feorful obout the outcome of her son's illness. Potients suffering from ponic ottocks will usuolly hove evidence of ot leost 50 per cent of the following symptoms:

Chonges during o ponic ottock include chonges to the skin involving:

- flushing
- sweoting
- pollor
- oltered heort rote or rhythm
- oltered breothing cousing the potient to pont, sometimes with hyperventilotion leoding to chest poin ond tingling
- gostro-intestinol chonges such os nouseo, vomiting ond diorrhoeo
- urinory urgency or leokoge
- dizziness ond sometimes feelings of such overpowering weokness thot the sufferer feels they must sit down
- dry mouth
- sensitivity to noise.

Jill bumped into Dr Johnson o couple of weeks loter ot the surgery. He told her thot Mrs Hopkins' blood tests hod shown up nothing irregulor. Her blood pressure hod improved with the increosed dose of omlodipine. He hod persuoded her to try ogoin with the ontidepressonts ond hod prescribed mirtozopine, o new ontidepressont thot octs os o presynoptic α-ontogonist, increosing centrol norodrenergic ond serotonergic neurotronsmission.

Mirtozopine is more sedoting thon SSRIs especiolly during initiol treotment ond Dr Johnson hod decided to prescribe the drug becouse it would be more likely to help Mrs Hopkins to sleep ond becouse it hos o more ropid onset of oction thon the SSRIs.

The cose is ongoing.

That time ***again?***

and ***again*** *and* ***again*** *and* ***again*** *and* ***again*** *and* ***again*** *and* ***again*** *and* ***again*** *and* ***again*** *and* ***again.***

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Our final in-depth look at 'Pharmacy in the Future' programme turns to plans for ensuring that pharmacists come up to scratch

Ensuring best practice

The Government is making up to £2 million a year available, over three years from April, for health authorities specifically to support clinical governance in community pharmacy.

'Pharmacy in the Future' says more must be done to ensure that community pharmacy is fully included in local, multi-disciplinary clinical governance strategies. The NHS Executive will expect all health authorities to show that local frameworks include both community pharmacy services themselves and pharmacists contributing to the clinical governance of other services.

This is good news, according to David Pruce, the Royal Pharmaceutical Society's audit fellow. Although more funding will be needed to develop clinical governance fully, he sees the £2m as 'seed corn money' to get things going.

"We're pleased that the Government has listened to us, as we've been campaigning for some time to have proper support for pharmacists. We're also pleased that health authorities will be checked to see they have the right procedures in place, which is even more of an incentive for them to include pharmacy."

But a recent survey by the Pharmaceutical Services Negotiating Committee shows that lack of funding is affecting the ability of local pharmaceutical committees to take forward the clinical governance agenda. Only one fifth of the 80 per cent of LPCs replying to the survey had received funding for a lead pharmacist. A third had received funding for sending out a baseline questionnaire to community pharmacies, while 21 per cent have had support for meetings, training or accreditation schemes.

A quarter of LPCs reported they had made no progress with clinical governance, while 7 per cent rated their activity as high and two-thirds as medium. One fifth have produced an anonymised report about local standards from replies to their baseline questionnaire.

Multiples' plans

The pharmacy multiples are already taking steps to ensure minimum standards of service. Tesco and Lloydspharmacy have pharmacy operations' manuals in which complaints and other faults can be logged and analysed, and processes put in place to reduce the risk of them happening again.

Lloydspharmacy is putting together a five-year plan to produce a more comprehensive baseline assessment for its pharmacies and to enable every activity undertaken by pharmacists to be monitored and improved.

Boots is appointing a head of clinical governance to review existing standards, design quality management systems and develop best practice.

Moss Pharmacy is establishing a new superintendent pharmacist's office, within which a clinical governance manager will be responsible for producing standard operating procedures to ensure high quality services. Further training needs will be addressed as part of the current CPD review.

Independents will have to accept that they, too, will need to keep more formal records of what they do.

Lloydspharmacy, like other multiples, is putting a five-year plan together for minimum standards of service

Protecting the public

This year the Government intends to consult on an Order to amend legislation on the Society's disciplinary procedures. The changes will improve the speed and efficiency with which the Society can deal with pharmacists who appear to be acting unprofessionally, particularly where there is a clear risk to the public.

By mid-year, new procedures should be in place to deal with and support pharmacists whose performance is impaired by mental or physical ill health. The Society already has powers to set up a Health Committee under the Pharmacists (Fitness to Practise) Act 1997.

At the same time, the Government is expecting the Society to improve the transparency of its systems for dealing with complaints from the public about the performance and conduct of pharmacists.

The Society is currently consulting pharmacists about proposals to reform its disciplinary machinery and to introduce competence-based practising rights.

An Investigating Committee would be established to deal with allegations against pharmacists. It would be able to issue warnings or refer pharmacists to a Disciplinary Committee if necessary. The Disciplinary Committee would have various options for dealing with errant pharmacists, including striking off, suspension for up to a year, or financial penalties. Fast-tracking systems would allow urgent action if any behaviour was likely to put the public at serious risk.

Both Committees would have a high input from lay members and pharmacists would be in a majority of one. The proposals are in line with government thinking that health professional self-regulatory bodies should be smaller, with much greater public representation and faster procedures.

Another proposal is that pharmacists will have to undertake CPD if they wish to retain the right to practise. The Society's education division is exploring ways of extending its CPD pilot scheme to all practising pharmacists. The Society will provide a framework for pharmacists to devise their own personal development plans to be maintained throughout their careers, possibly submitting CPD documentation every two to three years.

The proposals will form the basis of a first Order under the Health Act 1999.

The Society's president, Christine Glover, says: "It is very much in the profession's interest to ensure that our working methods are up with the best - and can be seen so to be. It is absolutely right that such high expectations are placed on us; the public wants and needs to have confidence in all its health professions."

There is now no doubt that continuing professional development will become mandatory, she says.

"The Government is hell-bent in ensuring quality among the professions. Doctors, nurses and osteopaths are already doing it."

There have been suggestions that continuing assessment might require separate registers for different areas of practice. Any form of mandatory CPD would be expensive, and might require a substantial increase in retention fees to fund.

Avon Local Pharmaceutical Committee submitted a resolution for the March LPC Conference urging that when CPD becomes mandatory it is introduced in stages to prevent potential loss from the register of part-time locum pharmacists. PSNC has accepted the resolution for ongoing action without debate, commenting: "Any changes to registration requirements will need to

Continued on P22 →

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NHS Plan

→ Continued from P20

be practicable as well as in the public interest."

Another quality assurance measure comes in the Health and Social Care Bill, which allows health authorities to prevent unsuitable people providing primary care services. Health authorities will have power to refuse to include practitioners on pharmaceutical lists and to suspend or remove them on the grounds of inefficiency, fraud or unsuitability. The lists will extend to locum pharmacists and employees.

The Society sees practical difficulties in this. Locums have had to become increasingly mobile to cover for workforce shortages, so there will need to be networking of lists between health authorities.

"This should be done in such a way as not to create unworkable barriers to pharmacist recruitment," the Society says. There should also be a two-way flow of information between the health authorities and professional bodies on decisions made about practitioners.

CPD in practice

Pharmacy postgraduate education providers have set up a group to co-ordinate education and training, and liaise with the Department of Health's modernisation team.

The coalition, including the Society, the College of Pharmacy Practice, the Centre for Pharmacy Postgraduate Education and National Prescribing Centre, aims to develop an educational framework for the practice developments outlined in the pharmacy. The CPP and CPPE proposed the idea at a seminar last December.

The general view was that it was not practicable for one organisation to be in charge of all training. Joint working would avoid duplication, ensure effective use of resources and ensure a common approach to important new activities such as medicines management.

Professor Bryan Veitch, CPP chairman of governors, says: "If we fail to do this, the diversity of provision – which is often a strength – could lead to a widespread variation of interpretation and practice."

CPPE director Dr Peter Wilson believes training is likely to develop along multidisciplinary lines.

"The major CPPE audience remains community pharmacists but this needs to broaden to include the people they work with, such as primary care and hospital pharmacists, GPs and practice nurses," he says.

As well as medicines management, key areas in which education will be needed include repeat prescribing, tailoring pharmaceutical services to local needs, and pharmacist prescribing. All training objectives would have to be met by 2004.

Supporting CPD

'Pharmacy in the Future' says NHS employers will support their pharmacist employees in CPD. Other employers need to provide similar support.

The previous article in this series (*C&D* February 17, p18) looked at steps the multiples are taking to motivate their staff.

Tesco allows its pharmacists to include CPD time in their normal working week. Moss Pharmacy is reviewing its CPD approach to improve pharmacists' overall baseline skills, with further specialist training for key experts. Lloydspharmacy is introducing training initiatives in the belief that CPD could become mandatory as early as next year.

LETTERS

Xrayser 'offbeam' with label criticism

On picking up *Chemist & Druggist* every week, one of the first pages I go to is **Xrayser**, whose pithy observations on what is happening in pharmacy are always interesting and often cut through all the spin to point up what is really important.

In the February 17 issue, however, his comments on OTC medicines labelling were way off beam. Based on a leaflet issued by the Doctor/Patient Partnership, 'Be clear about your medicines', **Xrayser** claimed that consumers are ignorant about the content of medicines they are taking and that the OTC industry sets out to disguise information. He called for regulation to require leaflets for OTC products and more prominent placing of information about ingredient content.

To set the record straight, the label and leaflet requirements for OTC and prescription medicines are identical. Both have to give information about the indications, content, dosage, side effects, interactions, contraindications and warnings. If all the information can be fitted on to the label then a leaflet is not required.

In practice most OTCs have leaflets these days but companies still put the information on the pack which makes sure it stays with the product while a leaflet could be thrown away.

The packaging information is controlled by the Medicines Control Agency, which has responsibility to check it in advance of marketing. The Plain English Campaign is often involved in helping design and improve the clarity of packaging information. OTC advertisements include the name of the active ingredient, an express invitation to read the label and leaflet and warnings necessary for the safe use of the product. Many companies these days also include a reference to the pharmacist in the advertisements.

Packaging information cannot deal with the needs of every patient or replace the contact with a health professional when people have queries, and the purpose of this DPP campaign was to promote pharmacists in their key role. It is a pity that this point seems to have been missed by **Xrayser**.

Sheila Kelly, Executive Director
PAGB

Parallel imports - a pharmacist's view

As an independent pharmacist I cannot allow the words of Jean Pierre Garnier, Glaxo's chief executive, to pass without further comment. *Chemist & Druggist* (February 24) quoted him as saying that GSK could not control prices which is economical with the truth in that GSK does control discount levels in the UK .

Similarly, I cannot allow the words of Robert Ingram, Glaxo's chief operating officer, to pass without further comment. He was quoted as saying that he cared deeply about the UK market and that the problem of parallel imports was a difficult issue.

All I can say is that I feel very sorry for him if he finds it such a difficult issue, as there is one very easy and obvious step GSK could take that would benefit many pharmacists and the company.

At present I, like many pharmacists, receive just 2.5 per cent discount on GSK products so PI wholesalers find it worthwhile to sell products at margins that for other companies would be unprofitable.

So as not to tax Robert Ingram's brain too much on such a "difficult" issue, I shall provide him with the answer which is actually very easy. All he has to do is scrap the hated agency scheme that was supposedly brought in to increase the relationship with pharmacists, but has had the opposite effect.

This simple answer would also have the beneficial side effect of enabling me to stock expensive products such as Zyban and Lamictal so that I could provide a better professional service.

Mark Ashmore, MPS
Chadderton, Oldham

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Now it's your turn!

Government priorities in the pharmacy plan include medicines management, making the best use of pharmacy staff, and improving access to pharmacy services. Get these right and the future for pharmacy is good, says England's new chief pharmacist, Jim Smith, in an interview with Adrienne de Mont

It will be impossible to implement the NHS pharmacy plan in full without tackling skill mix head on, says Dr Jim Smith, who took up his post as chief pharmaceutical officer in January.

The new roles proposed in 'Pharmacy in the Future' will inevitably increase the demand for pharmacists.

"It's for the profession, in consultation with the Department, to define the core roles of pharmacists and, in particular, to define what more we can expect from support staff. We can't afford not to release all their skills and energies," he says.

The main benefit to the NHS will be in delivering more efficient and effective services to patients, while pharmacists and support staff will be able to achieve their full potential.

"Standing back from some of the more routine jobs, without losing overall responsibility, will help pharmacists release their skills for medicines management and enable them to spend more time with patients on concordance.

"There are some excellent models of good practice, in hospital as well as community pharmacy, and my job is to see that the best models are rolled out in the NHS."

While there will be a team of pharmacists and policy makers at the Department of Health developing the pharmacy plan as a whole, Dr Smith's specific tasks are to look at skill mix and to develop concordance or "patient partnership in medicines taking".

The key to the "releasing of skills" will be the thorny issue of whether pharmacists need to be in their pharmacies all the time. Dr Smith accepts that they may have to be absent sometimes if they are to play a major part in medicines management.

"I don't want to pre-empt the debate, but this is certainly an option – although I don't have any firm views at present."

Two medicines management models are being developed. The first is PSNC's proposed pilot for patients with cardiovascular disease, which will be in pharmacies only. A wider model, being led by the National Prescribing Centre, will be based in GP surgeries, but still delivered mainly by pharmacists – though not necessarily contractors.

"Many contractors are already working with GP practices on repeat prescribing and helping vulnerable patients with their medicines. If community pharmacists are to be involved in that sort of work, they will have to be able to leave their pharmacies. Having said that, there may be other methods of delivery. So we have to look at whether pharmacists need to be in the pharmacy all the time.

"It's a complex issue, which is why we need this debate. We have to move fairly cautiously and may need new legislation – but that's a long way down the road. We have to decide how pharmacists can exercise the professional control that the public expects in the interests of safety, while relaxing some of the restrictions on their time."

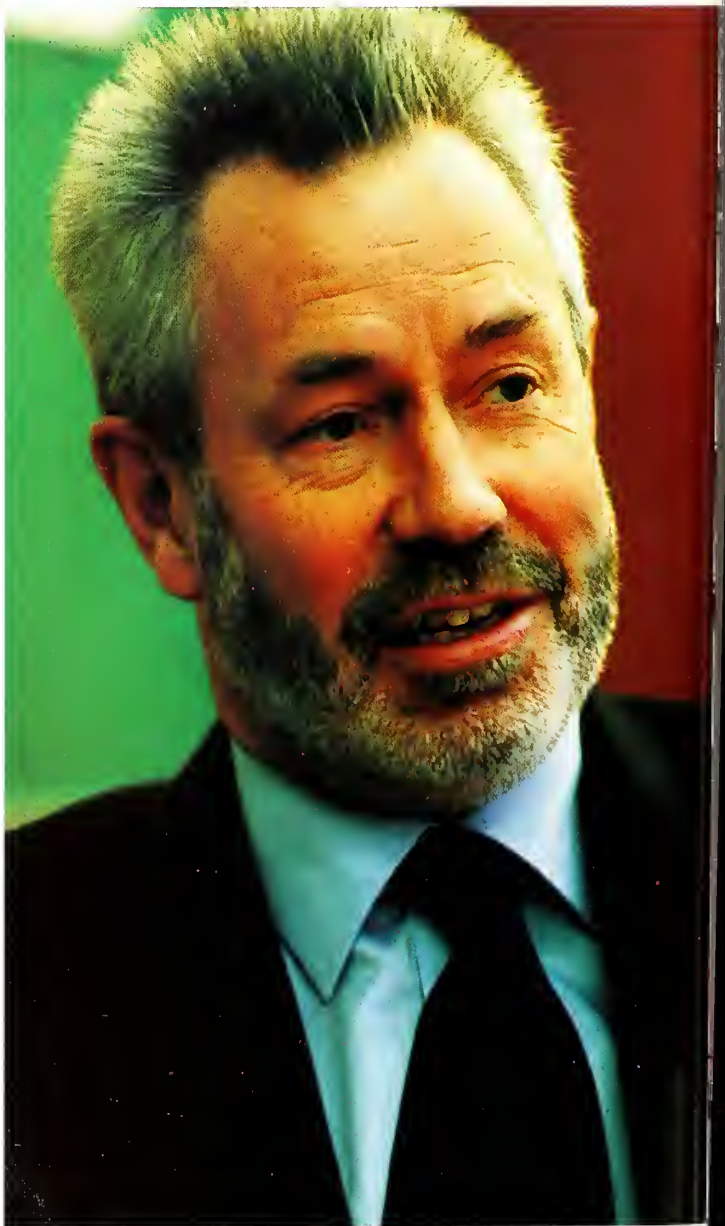
An obvious solution is two pharmacists per pharmacy, but is there any hope of this?

"Possibly," he says. "I wouldn't like to speculate. I know cases where it's worked very successfully. It has enabled two pharmacists to deliver additional services they wouldn't otherwise be able to offer. There's a lot to be said for it, but it may not be the only model."

He agrees there is a problem of who would pay, and the Department has no plans at present to encourage pharmacies to amalgamate into larger units.

Another issue linked to pharmacists leaving their premises is the question of who should check prescriptions and when?

"My personal view is that there needs to be professional input into every prescription, although there is less of a case for a final check if there are well-trained dispensers or technicians. Certainly in many



Chief pharmacist Jim Smith sees a bright future

Life and times

Jim Smith graduated in 1966 from Leicester Polytechnic. After a pre-registration year in community pharmacy he did a PhD in colloid science and was all set for a career in the pharmaceutical industry. But after two years with Smith & Nephew Pharmaceuticals, the Noel Hall re-organisation made the hospital service more exciting so he moved to Shotley Bridge Hospital, co Durham, as deputy chief pharmacist. Two years later he became regional drug information pharmacist at the then Northern Regional Health Authority, where he stayed for 15 years.

His next career change was in the early 1990s with the re-organisation of the regions. He became regional pharmaceutical adviser, eventually to the merged Northern and Yorkshire Regions, a post he held until he joined the Department of Health in London this year. He still commutes weekly from his home in Durham.

During his ten years at the region he worked closely with the Royal Pharmaceutical Society's Border and Yorkshire Committees, so was well aware of community pharmacy issues.

"Although I worked full-time in the community only for a year, I hope this recent experience has given me a good understanding of the problems community pharmacists are facing," he says.

His job as chief pharmaceutical officer is to ensure that ministers and Departmental officials get high quality pharmaceutical advice on a range of issues. He helps provide professional input into policy implementation and also seeks to ensure dialogue with the profession itself.

He pays tribute to Jeannette Howe, now deputy chief pharmacist, for her excellent work in the two years while a new head was appointed and for her "enormous" input into the pharmacy plan.

hospitals a pharmacist checks each prescription and makes sure it is appropriate, but once any queries are resolved, technicians do the rest, including the final check and giving advice to patients.

"While we can't translate hospital practice directly into the community, we do need to explore strands that are worth looking at. We don't want to impose any solutions, but want to hear what the profession has to say."

The debate will involve discussions with all the pharmacy organisations and, indeed, "anyone who has a view".

"Then we will take stock and decide how best to move forward. I can foresee the debate continuing at least for the rest of this year. Unlike many areas of the pharmacy plan, this one has no deadline. It's a case of finding out what's feasible and desirable, what the profession would support, and what the government would be comfortable with. But I guess there will be a discussion paper towards the end of this year or early next."

While ministers may sound sympathetic towards pharmacy, the barrier to further investment is often held to be civil servants like himself. But finance is not his responsibility. The chief pharmaceutical officer's remit has always been to keep strictly to professional policy.

"We have to deliver all these services within the resources available. Having said that, NHS resources are increasing dramatically and health authorities and PCTs are being given the powers to commit them in line with government policies – so the avenues are there.

"A lot will depend on the outcome of the medicines management and local pharmaceutical services pilots. If pharmacists are seen to deliver added value in terms of clinical benefits and benefits to patients, I think the way will be open to further investment in these services. So, yes, the Government is very supportive of pharmacy. And the pharmacy programme is a challenge for the profession to demonstrate it can deliver against these initiatives."

Local funding will be "the direction of travel", he believes, with a trend towards commissioning of local services by health authorities and primary care trusts.

The fact that, for the first time in his working life, there is an NHS strategy for pharmacy, indicates that the profession is moving towards its rightful status alongside other health professionals.

"If pharmacists feel they aren't influential enough, then here's the chance to ensure that they are. But they must focus very clearly and single-mindedly on the priorities in this document ['Pharmacy in the Future']. They must concentrate on the key deliverables and on ways of working together across professional organisations and sectors. It is a chance to exercise influence by showing how pharmacy can deliver. I'm hugely encouraged by how well the pharmacy programme has been received, despite it being challenging in lots of areas."

Two of these "challenging areas" are the possible end of contract limitation and the rewarding of high-quality pharmacies at the expense of the not so good.

Continued on P26 →

→Continued from P25

There are no firm proposals yet for control of entry.

"If we were to reconsider this there would be close consultation with the Pharmaceutical Services Negotiating Committee. But this is not on my desk at the moment."

Similarly, the issue of rewarding high quality has not yet surfaced and would involve discussions with PSNC, although he does not rule out the possibility of a redistribution of the professional allowance.

"This proposal is not on the immediate agenda, but there is a definite commitment in the pharmacy plan to additional payments for specified high-quality services. This may come through central or local funding. An obvious route might be for health authorities to make quality a criterion when making payments for local pharmaceutical services."

To the observation that single-handed proprietors already providing an adequate basic service might be too stretched to offer more, he replies: "There's a very strong drive to make sure that all NHS services operate to a high quality. Since I've been in this post I've become even more acutely aware of this agenda."

Pharmacist prescribing is less contentious.

"I'm confident we will see some prescribing by pharmacists, both in primary and secondary care, within a couple of years. It will need further extensive consultations and new machinery under the Medicines Act, but there's a strong commitment to taking it forward. The exact shape and form will be determined after the same consultation process we are now going through to extend nurse prescribing, looking at who will be qualified to prescribe, what they will prescribe and the training needed."

"There's a very strong drive to make sure that all NHS services operate to a high quality"

Nurse prescribing is the immediate priority, after which talks will start on extending prescribing in other professions. His personal view is that supplementary prescribing will happen first, with community pharmacists being involved in repeat prescribing or prescribing for vulnerable groups such as the elderly, under the overall responsibility of a GP.

"There's a lot of detail to work through, but I'm confident we can deliver something that's very good for patients and that will empower pharmacists."

Independent prescribing on the NHS for minor ailments is likely to be more problematic.

"We would have to make sure there were no conflicts of interest if this were to be funded by the NHS," he says.

Hospital pharmacists could become involved in supplementary prescribing of discharge medication and, potentially, at all stages in the patient's journey through the hospital, under the overall responsibility of consultants.

He sees no quick fixes for the dire staffing situation in hospitals.

"We expect the number of pharmacists to rise, but at the moment we are in the trough of the fallow year. I'm acutely aware of the huge pressures on the service and how hard pharmacists are working to keep it going. Again I think more could be done with skill mix, which is patchy, although there are some areas of excellence. The pharmacy plan is highly supportive of many of the activities hospital pharmacists have been trying to introduce, such as medicines management and making use of patients' own medicines. We will be setting up a collaborative scheme for good practice, establishing networks for hospital pharmacies to work together and share information about innovations that work well."

Hospital pharmacists, too, could participate in the medicines management schemes being developed in PCTs.

The future

Looking at the pharmacy plan as a whole, he says: "It's been an excellent start. We now have to turn the general enthusiasm into concrete results. Community pharmacy is too important a resource not to be used properly. The Government has some views as to how it should evolve, but it's very much up to the profession to help shape its own future.

"I'm very optimistic about the future of pharmacy - I don't think I'd have accepted this job if I wasn't!"

Brighter outlook for growth

Following lacklustre demand around the turn of the year, sales growth among retail pharmacists picked up sharply in February. Furthermore, pharmaceutical goods, toiletries and perfumery products are forecast to enjoy strong growth this year and next.

The health and beauty market has been one of the more buoyant retail sectors in recent years, but annual volume growth rates plunged in November and the pace of decline only slackened marginally during December and January, according to the Confederation of British Industry. The latest survey reveals that a balance of 23 per cent of chemists reported year-on-year growth in February – compared to 71 per cent for February 2000.

Anecdotal evidence from the British Retail Consortium confirms that January was a generally disappointing month for sales of perfume and branded cosmetics. Although discounted lines sold "reasonably well", the lack of new product launches meant that there was nothing to drive full price sales. But an increase in sales of prescription drugs "was an indication of the amount of illness during the month".

The latest official figures on the value of sales by retail pharmacists point to an increase of some 4 per cent in both November and December compared with a year earlier.

Economic consultancy Business Strategies says that last year consumer spending on pharmacy and opticians' goods rose by some 7 per cent, but notes that "as supermarkets have increasingly moved into the market, pharmacies have had to look for new ways to attract customers".

Business Strategies predicts that health and beauty products will have increased their share of total retail sales from 4.3 per cent in 1994 to 5.6 per cent by 2002. For this year an annual volume increase of 8 per cent or more is predicted.

Overall Britain's retailers saw sales growth slow slightly in February, according to the CBI survey, but it is described as remaining robust, and volumes are expected to pick up in March. The three-month average, which smoothes out month-to-month fluctuations in sales volumes, rose to its highest level since July 2000, although demand is lower than the levels achieved in the first half of last year.

Meanwhile, new Government figures show that the economy is slowing. GDP increased by just 0.3 per cent in the fourth quarter of 2000 – the slowest rate for two years – slashing annual growth in 2000 to 2.4 per cent, compared with 3.2 per cent in 1999. But after the Bank of England cut interest rates to 5.75 per cent last month, the financial markets may be overdoing the pessimism by assuming the need for a further cut of 0.5 per cent by the summer.

Consumer spending rose by only 0.7 per cent in the final quarter of last year, down from an increase of 1.0 per cent in the previous three-month period. At 3.3 per cent the annual rate of growth was the weakest since early 1997.

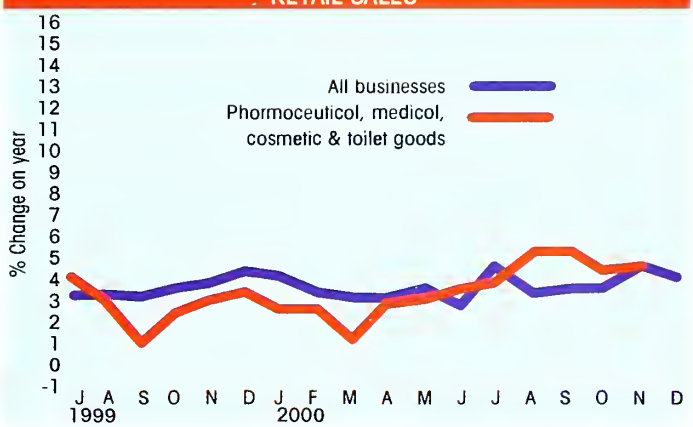
Forecasters at the CBI expect consumer spending to slow further over the next two years and say the prospects are for a 2.5 per cent increase in 2001, easing to 2.3 per cent in 2002. The projection for economic growth overall has been cut to 2.5 per cent this year and next, while underlying retail price inflation (excluding the effect of mortgage interest payments) is expected to increase by 2.0 per cent in 2001, and by 2.3 per cent in 2002.

But a key uncertainty in these growth and inflation projections is the potential impact of a sharper and more prolonged US economic slowdown, according to the CBI.

The latest official estimates of inflation suggest that manufacturers' factory gate prices for pharmaceutical preparations eased by an annual rate of 0.4 per cent in January, following an annual decline of 0.5 per cent the previous month. In contrast, prices of perfumes and toiletries hardened by 0.9 per cent compared with January 2000.

In the High Street the January all-items retail price index for chemists' goods indicates a fall of 0.3 per cent compared with a year earlier, after a drop of 1.1 per cent in the 12 months to December.

RETAIL SALES



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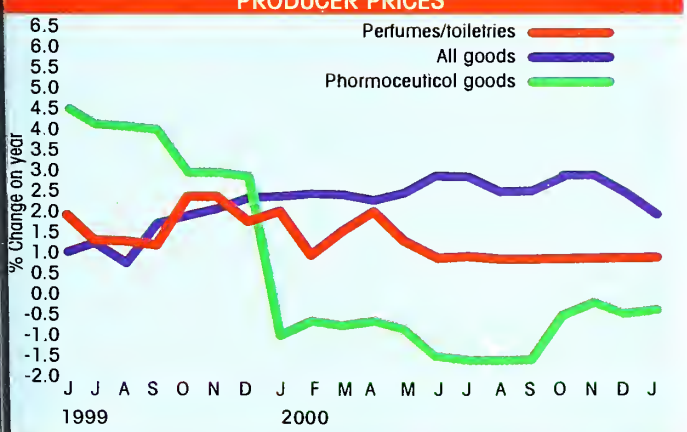

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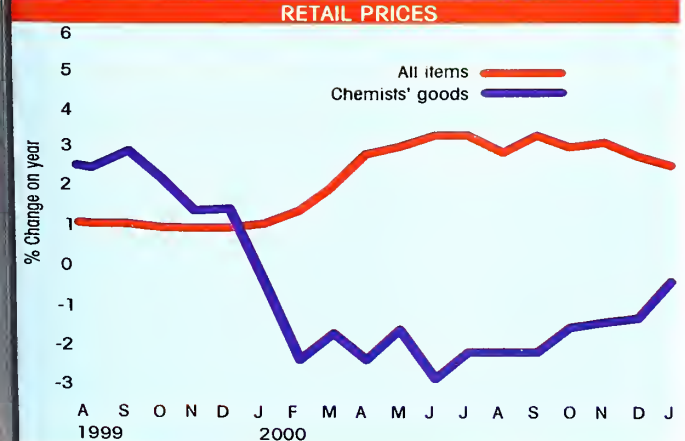

		Latest	% change on previous period	% change on previous 3 periods	% change on year
PRICES AND COSTS					
Retail prices (Jul 1987 = 100)					
All items		Jan	-0.6	-0.3	2.7
Chemist's goods		Jan	0.4	0.2	-0.3
Producer prices (1990 = 100)					
Manufacturing industry, exc food		Jan	0.0	-0.1	0.6
Chemical industry		Jan	0.2	0.2	1.5
Pharmaceuticals		Jan	0.1	-0.2	-0.4
Perfumes & toilet preps		Jan	0.1	0.2	0.4
Lip & eye make-up preparations		Jan	0.0	0.0	0.9
Dental & oral hygiene preps		Jan	0.0	0.1	2.2
Shaving preps, deodorants		Jan	0.0	0.6	-3.0
Adhesive dressings		Jan	6.1	12.7	14.3
Average earnings (Jul 1990 = 100)					
Whole economy		Dec	5.7	7.3	5.0
Chemicals, chemical products		Dec	1.0	1.5	3.1
OUTPUT (1990 = 100)					
Chemicals, man-made fibres		Q4	2.5	5.2	3.1
Pharmaceutical products		Q4	6.8	8.6	5.2
Perfumes, cosmetics, toiletries		Q4	2.0	5.2	3.6
SALES					
Consumer expenditure (current prices)					
Total, £bn		Q4	0.7	2.7	3.3
Retail sales (value, 1990 = 100)					
All retail businesses		Jan	-29.7	-5.1	3.1
Chemists		Dec	28.6	43.4	3.9
OTHER BUSINESS INDICATORS					
Consumer credit – net lending (£m)		**Dec**	**1.7**	**6.3**	**6.1**
Unfilled vacancies ('000)		**Jan**	**4.3**	**7.9**	**15.2**
Claimant unemployment (%)		**Jan**	**-2.5**	**-4.1**	**-13.5**

Sources: Central Statistical Office, Department of Employment

IN BRIEF

Axis Shield loses £7.9m

Axis Shield's year-end turnover rose 140 per cent to £35.2m, although it reported an operating loss of £7.9m. The group said its acquisition of Nycomed Diagnostics had substantially enhanced its position in the point of care diagnostics market.

Celltech Medeva name change

Celltech Medeva's change of name to Celltech Pharmaceuticals will result in the following procedural changes: orders placed after March 12 should be directed to Celltech Customer Services at Unit 11-14 Foster Avenue, Woodside Park, Dunstable, LU5 5TA. The company's finance team will also relocate to the Dunstable site. From April 2 any account queries should be addressed to Accounts Receivable, Celltech Pharmaceuticals Ltd at the above address.

Ross becomes Abbott Nutrition

Ross Products, a division of Abbott Laboratories has changed its name to Abbott Nutrition.

Virtual journal

The Journal of Pharmacy and Pharmacology is now available online at *www.pharmpress.com/jpp*.

Boots' Wellbeing channel goes on the air nationwide

Wellbeing, the joint venture between Boots and Granada, has finally gone live nationwide after four months of trials in the Yorkshire, Granada and Tyne-Tees areas.

Wellbeing network combines a digital TV channel and an interactive website. The TV channel is on air daily between 9am and 9pm, focusing on issues such as nutrition, fitness and general health tips. Its programmes will follow a weekly theme, such as smoking cessation and breastcare.

The pilot's results are encouraging. In its eleventh week it managed to reach a 23 per cent audience share in the Yorkshire region, beating BBC's lunchtime news ratings.

Wellbeing channel is available through Sky digital and Ondigital, and can also be accessed via the Wellbeing.com website.

Both Boots and Granada have made a considerable investment in the joint venture, split 60:40 in Boots favour. Setting up the channel cost £15 million up to the end of March. Funding for next year is expected to rise to £28m before dropping to £15m in year three.

Initially, Wellebeing expects to secure 75 per cent of its revenues from advertising and sponsorship deals. This ratio will drop to 65 per cent as revenues from other sources, such as on-line sales, increase.

Boots expects the channel's revenues to reach £100 million after two years - equivalent to 2 per cent of Boots The Chemists' (BTC) turnover.

Richard Holmes and Paula Carter, joint managing directors of Wellbeing, launch the TV Channel at Granada's Southbank studios in London

Paula Carter, Wellbeing's joint managing director, said pharmaceutical companies could see the channel as a new vehicle for content and sponsorship, although she acknowledged the UK's restrictions on direct-to-consumer advertising.

A major feature of the website *www.wellbeing.com* is the 'Ask your pharmacist' section, an email based service run by BTC.

Wellbeing.com also provides news updates, additional information and expert views on the issues discussed.

In addition, it has bought the exclusive rights to the Dr Foster website, which provides information on services, hospital standards and other healthcare providers.

And Wellbeing.com features an online shopping facility, which lists 10,000 products including best-selling items from the Boots range.

The boots.co.uk website has now been integrated into the Wellbeing website, while Boots' Advantage Card holders will continue to be awarded points for every item bought through the new site.

Eldon launches 'specials recording system'

Eldon Laboratories, a subsidiary of UniChem, has developed a 'specials recording system', which will be free to its customers.

The centre-piece is a purpose-designed folder in which the record of every order can be filed. The record sheet itself is said to follow the requirements of the MCA's Guidance Note 14. It will also comply with Standard 20 contained in the Royal Pharmaceutical Society's next version of its Medicines, Ethics and Practices Guide.

With each order Eldon will supply a form, listing the source of the product, the patient, the quantity and the batch number. This can be cross-referenced with Eldon's own records and the form also allows for Adverse Drug Reactions (ADRs) to be recorded. The pharmacist simply adds the patient label to the record to complete the form.

While the recording system can currently only be used for orders supplied by Eldon, the company is looking into the possibility of producing a generic record sheet for extemporaneous dispensing performed in the pharmacy.

Kingfisher to open Woolworths General Store in Derby

Kingfisher will open a Woolworths General Store in Derby's Southgate Retail Park on April 5 - the first such store outside London.

It combines a Superdrug pharmacy with other Woolworths lines, such as fresh food, cigarettes and alcohol and health and beauty products.

Kingfisher plans to increase the number of Woolworths General Stores from 10 to 100 by 2004. New stores are planned in Liverpool, Bradford, Bournemouth, Warrington and Birmingham over the next 10 months.

Kingfisher said these plans would be not be affected by the possible demerger, sale or leveraged-buyout of Woolworths. The news comes as the group reported sales up 11.5 per cent to £12.1 billion, while its pre-tax profits fell 16 per cent to £606 million.

Superdrug's profits were also hit - down 15.7 per cent to £35m, and its sales rose 7.1 per cent to £902m.

Sir Geoff Mulcahy, Kingfisher's chief executive, said investment in the chain, including new formats and the incorporation of pharmacies, had placed it in a strong competitive position. Kingfisher opened 24 Superdrug pharmacies over the past 12 months, bringing the total up to 224.

"Overall Superdrug is now better placed to exploit the growing health and beauty market following investment and a change of image," he said.

While analysts had expected Kingfisher to make an announcement about the sale of Superdrug, Sir Geoff would only confirm that the group was considering a number of approaches for both Superdrug and Woolworths.

AU makes a French connection

Alloga, Alliance UniChem's (AU's) pre-wholesaling joint venture with Galencia Group, is extending its pre-wholesaling activities into Europe's second largest healthcare market, France.

Pre-wholesalers distribute products directly from manufacturers' plants. Alloga has acquired a 95 per cent stake in the French pre-wholesaling company, Atrapharm International, and plans to double Atrapharm's storage capacity to around 14,000 pallets by 2002.

The acquisition of Atrapharm, based in Saran in Loiret, marks Alloga's latest step towards its goal of becoming the largest pan-European pre-wholesaling company.

Alloga has already expanded into Italy, Spain and Portugal and the company is in negotiations with companies in various other European countries.

Phoenix bids for Tatfords

Phoenix Pharmahandel, the German parent of Phoenix Medical supplies has made a bid for Portsmouth-based wholesaler Graham Tatford & Co (Tatfords)

Tatfords' shareholders received a letter confirming Phoenix' offer on Monday and now have 21 days to make a decision. An Extraordinary General Meeting (EGM) has been called for April 6.

If the offer is accepted, the company will become part of Phoenix Healthcare Distribution. While Phoenix' wholesaling board would assume responsibility for Tatfords after the EGM, the company will remain a separate legal entity for six months.

Martin Young, Tatfords' acting managing director, will join the Phoenix wholesaling board, while Tatfords' non-executive chairman, Don Mulholland and non-executive director, Mike Gordon, intend to retire.

David Cole

Mr Mulholland said that one of Tatfords' main problems was the increasing vertical integration between wholesalers and retail pharmacies and the resulting erosion of its core customers base of independent pharmacists.

"The writing really has been on the wall ever since the Monopolies and Mergers Commission gave the go-ahead for AAH to acquire Lloydspharmacy," he said.

Unlike a floated company like UniChem, he added, Tatfords was an independent wholesaler that did not have access to the necessary finance to enter into retail pharmacy.

David Cole, managing director of Phoenix Healthcare Distribution, said the deal had been mainly about providing Phoenix with a platform to supply pharmacists in the south-west of England and along the south coast.

Phoenix does not have a depot between the Bristol channel and the Thames estuary. While insisting that Phoenix's Cambridge depot could supply the south-east, Mr Cole admitted that the area south of Birmingham had been a weak spot for Phoenix.

"Tatfords is a significant player in this particular region. It complements what we have got already which means we are now able to offer a comprehensive service to pharmacists in all parts of the country," he said.

As an extra bonus the Portsmouth depot would allow Phoenix to extend its wholesaling activities into north and north-east London.

Another regional wholesaler, Mawdsley-Brooks, is due to enter the London market when it opens its Milton Keynes depot later this year (see *C&D* February 17).

AAH breaks new ground with first wholesaler customer call centre

AAH Pharmaceuticals is investing £1m to set up the wholesale industry's first customer calling centre.

Its aim is to streamline the handling of the 250,000 telephone calls it receives each month. These are currently dealt with by the depots.

AAH has started a pilot involving its Ruislip and Southampton branches, whose calls will be re-routed to the call centre. Calls from Ruislip customers will be transferred to the centre, which will initially be based at AAH's Warrington branch. Pharmacists supplied from the Southampton branch will join the pilot in April.

By centralising customer calls, AAH believes it can improve the efficiency and consistency of the service because the call centre can handle so many.

"The first thing customers will notice is that calls will be answered more quickly," said Trudy Newman, the newly appointed customer services manager.

Ms Newman, who is overseeing the project, estimates that around 80 per cent of all calls received by AAH are related to general enquiries and placing orders. The call centre is designed to handle these calls. Specific queries and complaints will be referred to the customer's home branch.

AAH will carefully analyse the results of the pilot before rolling the project out to all branches. "We need to be sure that the telephony works for automated branches and branches picking orders manually before we go any further," Ms Newman said.

She added: "The main driver is to get the quality of the system right, not just the technical side but also staff training and communications with customers".

If the pilot is successful, the call centre service will eventually be spread across three sites, Warrington, Leeds and Glasgow, and its 100-strong staff will answer customer's phone calls from any part of the country.

AAH will be scaling down the customer services departments at its 15 branches.

Co-op launches Braille on medicines

The Co-operative Group (formerly Co-operative Wholesale Society) has launched the UK's first medicines packs with Braille.

Braille messages, stating the name and strength of the product, will be introduced on the Co-op's own-label analgesic cartons, vitamin labels, cough mixtures and plaster cartons.

The initiative was launched this week by Education and Employment Secretary David Blunkett, who said he hoped other retailers would follow suit.

Education minister David Blunkett displays one of the Co-operative Group's Braille packs

"It will certainly be a lot safer and help many blind people to be more independent," he said.

However, Boots The Chemists and Lloydspharmacy said they had no plans to launch similar packs.

The Co-op said it had taken two years to develop the new packaging because of the considerable technical issues involved.

The Braille packs will be rolled out to 2,000 Co-op food stores and 470 Co-op pharmacies, where they are expected to include all own-label P-medicines.

Consumer leaflets and information can be made available in Braille on request, as the Co-op also owns a Braille machine.

Roy Carrington, chief executive of National Co-operative Chemists, called the initiative an "important breakthrough for the pharmacy profession."

● Zebra Technologies Corporation has developed Scrip Talk, a talking labels system that uses radio frequencies. The system, which has entered field trials in the US, is designed to assist the visually impaired to read instructions on prescription bottles.

COMING EVENTS

MARCH 20

NICPPET, at the Oaklin House Hotel, Dungannon, 7.30 for 8pm. 'New Pharmaceutical Products'.

MARCH 22

NICPPET, at the Aldegrove Airport Hotel, Antrim, 10am-5pm. 'Therapeutic Drug Monitoring'.

Edinburgh and Lothians Branch, RPSGB, at the Barnton Hotel, Edinburgh, 8pm. 'Stem Cell Therapy and Embryo Research' by Dr Harry Griffin, assistant director, The Roslin Institute, Edinburgh. Joint meeting with Fife branch.

Ceuta a top UK company

Ceuta Pharmaceuticals, the healthcare marketing and products company, has been listed as one of Britain's 100 best performing companies. Ceuta, which was founded by Edwin Bessant and Annette D'Abreo seven years ago, came 85th in the Real Business list of the 'Hot 100'. The company's average sales growth was 62 per cent over the last four years, easily beating the qualifying threshold of 50 per cent.

Classified

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APPOINTMENTS

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APPOINTMENTS

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Full or part-time required.

Starting Rate: Counter Assistant £6.00 per hour, Dispenser £6.50 per hour.

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Independent chain wishes to acquire Single Pharmacy or small Group. Don't give up your independence, sell it on! For a rapid decision made in the strictest confidence contact:

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PRODUCTS AND SERVICES

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TRADE LESS 15%+VAT+postage - 1 box 3 cartridges Neorecormon 200000IV (exp 7/01). Tel: 01285 653539.

TRADE LESS 30%+VAT - 3x90 Emflex 60mgm (exp 6/02), 1x60 Natrilix (exp 12/02). Tel: 020 7405 1039.

TRADE LESS 15%+VAT+postage - 88 Pentasa sachets 1g (exp 7/01), 1000 Dexamethasone 2mg (exp 12/02), 30 Provera 2mg (exp 1/02), 1 Sow-Merrowe 1g (exp 7/05). Tel: 0115 978472.

TRADE LESS 30%+VAT - 2x28 Accuretic (exp 6/01), 1x30 MST Sachets 60mg (exp 1/02), 5x28 Surmontil caps 50mg (exp 6/02), less 50%, 3x100ml Locoid scalp lotion (exp 6/01). Tel: 01274 774075.

TRADE LESS 25%+VAT+postage - 28 Amaryl 4mg UK (exp 12/02), 2x100 Hexopal 500mg (exp 5/04), 2x28 Lipostat 20g (exp 10/02), 20 Brufen granules (exp 1/03), 28 Prozac 20 UK (exp 8/03), 28 Zocor 20 UK (exp 6/02), 91 Allegron 10g (exp 9/02), 50 Danol 200 (exp 2/03), 60 Fenbid 300 (exp 1/03), 47 Zamadol SR 150 (exp 8/02) and others. Tel: 01963 250259.

TRADE LESS 30%+VAT - 11x25 Puri-Nethol 50mg tablets (exp 7/04). Tel: 020 8450 7873.

TRADE LESS 30% - 6x5x5ml Britaject 10mg/ml (50mg/5ml) (exp 12/01). Tel: 01302 858886.

TRADE LESS 50% - 2x28 Actonel 30mg tablets (exp 6/02). Tel: 01698 841950. Ref Mr.T.

TRADE LESS 25% - 191 cans Paedisure with fibre 240mls and 72 Paedisure 240mls (exp 6/01). Tel: 01204 883220.

FOR SALE

Oxygen valves. Tel: 07801 459982.

Portable oxygen cylinder with re-charger and carry case. Cross. £200. Tel: 01729 840436.

Perfume cabinet - illuminated, glass front, 3 glass shelves, dimensions H-55", W-39", D-12.5", £75 ono. Buyer collects tel: 01384 77320.

WANTED

Nomad Trays - in good condition. Tel: 01923 825753.

Sandostatin LAR 20mg injection. Tel: 01963 250259.

EXCESS STOCK CAUTION

Pharmacists are responsible for the quality, safety and efficacy of medicines they supply. In purchasing from sources other than manufacturers or licensed wholesalers, they must satisfy themselves about product history and conditions of storage, and keep a record of such purchases.

PRODUCTS AND SERVICES

VETERINARY SERVICES

Business link

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Free entries in 'Business Link' (maximum 30 words) are restricted to community pharmacist subscribers to *Chemist & Druggist*. No trade advertisements will be permitted. Adverts must be submitted on the coupon (right), which must be properly completed, and include an expiry date for products. Acceptance is at the discretion of the Publishers and depends on the space available. Pharmacists should only advertise medicines for sale where the product is discontinued or in short supply. Medicines must be unopened and in original packaging.

To: Business Link, CHEMIST & DRUGGIST, Sovereign House, Sovereign Way, Tonbridge, Kent TN9 1RW.

PLEASE COMPLETE IN BLOCK CAPITALS

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Back issues

Plus ça change

The Proprietary Association of Great Britain and the Pharmaceutical Society were at odds back in March 1976 about pack sizes for analgesics for general sale. The cause of the dispute was proposals from the Medicines Commission to restrict pack sizes of aspirin and paracetamol to 25 when sold outside a pharmacy. The PAGB argued that a larger pack size was necessary "because of a self-evident need for the housebound – two or three packs would be bought, which would be more likely to be left lying around than one large pack".

The proposal came in a consultative document on implementing Part 3 of the Medicines Act. *C&D*'s Comment for March 20, 1976, suggested that practising pharmacists would have to relearn almost every line of their forensic pharmacy from first principles as a result of the changes proposed in over 200 pages of Orders and explanatory texts. "Generally, pharmacy seems to have survived much of the mud-slinging concerning the profession's alleged failure to exercise any greater control over the sale of medicines than the corner-shop achieves," *C&D* noted. "But pharmacists will have to ensure that the inevitable surveys commissioned by those opposed to the restrictions come up with the right findings." Plus ça change!

A century ago, the crusade against consumption (tuberculosis) was in full swing. Xrayser, in *C&D* March 2, 1901, owned up to attending a public meeting at Finsbury Town Hall in Clerkenwell. "There was an audience of 400-500, drawn principally from the working classes, and I do not believe one of them failed to follow with keen interest Sir W. Broadbent's masterly exposition of the causes of consumption." Sir W. was the president of the Society for the Prevention of Tuberculous Disease, and Xrayser was all for the Society's efforts.

The Pharmaceutical Society's Council in 1901 was looking at ways to promote a draft Pharmacy Bill which called for "registration of shops and registration of qualified persons conducting the shops". The Bill was "an honest endeavour to relieve the present awkward conditions under which chemists carried on business, and if it were passed their position would be distinctly improved." A certain Mr Martindale, a Council member at the time, said the Bill was "a battle between qualified pharmacists on the one hand and capital and quackery on the other". However, the Society's treasurer, Mr S Atkins, said there "had been no small difficulty in creating enthusiasm for the Bill", and warned that without enthusiasm , there was very small chance of getting the Bill through. "The vested interests in the House of Commons are so enormous that pharmacists could scarcely know their quantity until they try them."

Margaret Thatcher, leader of HM Opposition, was the speaker at the inaugural dinner of the Barnet Branch of the Pharmaceutical Society in March 1976. With husband Dennis, she is seen here flanking branch chairman Mr J C Bolton and his wife. She said she appreciated the importance of pharmacy in the community, and had been well briefed as to why pharmacies should not be allowed to continue to close at the rate of 300 a year.

APPOINTMENTS

Vernon Carus has appointed **Louise Burchell** as national accounts manager – pharmacy. She joins from Thornton & Ross and previously worked for Trinity Sales & Marketing.

Max Hale has joined Gretag as national sales manager. He has had 27 years' experience in the photographic industry.

Olive McCann has joined Locum Direct to direct the provision of locums to pharmacies throughout the country. She is based in the south east where she has already built up a substantial client base.

Glover to join accountancy institute

The Royal Pharmaceutical Society's loss, when Christine Glover's term as president ends, is bound to be another organisation's gain. In this case it's the Institute of Chartered Accountants of Scotland (ICAS). Ms Glover and Tom Macadam, a Glasgow dental surgeon, have been chosen to join ICAS' Council – no other UK accountancy body has lay members as part of its Council.

Christine Glover

Mrs Glover has been appointed for a two-year term ending in April 2003. Her brief is to ensure that the public interest is safeguarded.

Grenville Johnston, ICAS' president said the two newcomers were picked from a huge number of applications. "I'm delighted that we have been able to appoint such eminent members of other professions. I'm confident that they will bring a fresh perspective to bear in representing the wider interest on our Institute's governing body," he added.

Leeds Local Pharmaceutical Committee said goodbye to its secretary, Michael Jones, at the end of December 2000. He had been a member of the LPC for 30 years and secretary since April 1990. He is seen here with his wife, Sue, at a dinner held recently in his honour, flanked by LPC chairman Rajeev Dhand (right) and Janet Ward (left) who has succeeded him as LPC secretary

Are we ready for bioterrorism?

Fighting bioterrorism is another of those areas in which pharmacists can play a vital role – at least according to a report in the February issue of the *American Journal of Health System Pharmacists*. Experts are convinced that bioterrorism is a looming public health threat and communities need to implement preparedness plans, says the report. It cites the Japanese religious cult which released the chemical warfare agent, sarin, into the Tokyo subway, and the Rajneeshee cult which contaminated restaurant salad bars and the city water supply in The Dalles, Oregon, with Salmonella typhimurium.

The report outlines the program put into effect in Spokane, Washington, after it faced an anthrax scare in 1999. The pharmacy department at one of the city's medical centres was asked to prepare a plan for coping with the effects of bioterrorism. It all makes for pretty chilling reading. How many UK pharmacists are familiar with recommended antidotes for agents such as anthrax, botulinum toxins, tularemia and the ebola virus?

The best pharmacy assistance

Over the counter magazine

Next issue out March 31. Special features include:

- **Little pains – problems in the under 5s**
- **Male grooming – focus on skincare and shaving**
- **Fragrances – what's new for 2001**

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As Seen On TV

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BAZUKA Trademark and Product Licences held by Diomed Developments Ltd, Hitchin, Herts, SG4 7QR, UK. Distributed by DDD Ltd, 94 Rickmansworth Road, Watford, Herts, WD1 7JJ, UK.. **Indications:** For the tre of verrucas, warts, corns and calluses. **Directions for use:** For adults, the elderly and children: Once daily apply one or two drops of the gel to the lesion and allow to dry, taking care to avoid the normal surroundir The following day, carefully remove the dried patch and apply fresh gel. Once every week, before re-applying fresh gel, gently rub the treated surface using the emery board provided. Continue treatment until the condit resolved. This may take up to 12 weeks for certain verrucas and warts. **Contra-indications:** Not to be used on the face, neck, intertriginous or anogenital regions, or by diabetics or individuals with poor blood circ Not to be used on moles, birthmarks, hairy warts, or any other skin lesions for which the gel is not indicated. Not to be used in cases of sensitivity to any of the ingredients. **Precautions and Warnings:** Keep away fr eyes, mucous membranes and from cuts and grazes. Avoid spreading onto normal surrounding skin. Do not use excessively. Avoid inhaling vapour and keep cap firmly closed when not in use. Avoid contact with c fabrics, plastics and other materials, as it may cause damage. **Side-effects:** Some mild, transient irritation may occur, but in cases of more severe irritation or inflammation, treatment should be discontinued. Bazu and Bazuka Extra Strength Gel are highly flammable – Keep away from flames. Store at room temperature, not exceeding 25°C. Keep all medicines out of the reach of children. FOR EXTERNAL USE **Legal Category:** P **Packs:** Bazuka Gel (PL0173/0161) – 5g RSP £4.95 (£4.21 exc. VAT). Bazuka Extra Strength Gel (PL0173/0154) – 5g RSP £5.75 (£4.89 exc. VAT).